SCHOOL DISTRICT of PICKENS COUNTY

Building success beyond the classroom

REQUEST FOR MEDICATION SELF ADMINISTRATION DURING THE SCHOOL DAY

POLICY JGCD-E (1)

Student Name _____ Date of Birth _____

School _____ Grade _____

Medication _____ Dosage _____

Purpose of Medication _____

Time (s) medication is expected to be taken during the school day _____

Possible side effects _____

Period of time medication may be self-administered: From (date) _____ to (date) _____

_____

Physician's Signature REQUIRED

_____

Physician's Name

_____

Address

_____

Phone

I hereby give my permission for _____ (student's name) to keep the above medication with him/her during school hours and to administer it to himself/herself as prescribed. I understand that this medication is to be kept in its properly labeled original container. My child understands the circumstances warranting administration of this medication and is responsible enough to keep it with him/her and to administer it to himself/herself. My child also understands that this medication is not to be distributed to any other student or district employee. I hereby release the School District of Pickens County from any and all liability associated with the self-administration of the above medication.

__/__/__

Date

_____

Print Name of Parent/Guardian

_____

Signature of Parent/Guardian

Approved: _____ Date _____

Principal or Designee