Bedford County Public Schools Physician/Parent Authorization To Administer Medication Permission to fax to medical office/ school/parent

Dear Parent or Guardian:

In order for Bedford County Public Schools to assist with administration of medication for your child during the school hours the following guidelines need to be followed:

- The physician needs to fill out this form for any prescription medication given. The name of the medication, dosage, route, purpose, side effects and time interval of medication to be taken must be included.
- This form needs to be updated as indicated if medication changes occur throughout the school year.
- The parent or guardian must sign this form requesting that the school district comply with the physicians order.
- Medication must be brought to school by the parent or guardian in a container appropriately labeled.
- The school must have a separate authorization form for each medication requested.

Name of Studen	t		Grade	
School		Teacher		
Medication		Dosage	Dosage	
Purpose of Medi	cation/Diagnosis			
Time of day medication is to be given		Route		
Possible Side Ef	fects			
Allergies	Discontinue Date			
Date	Physician Signature	Physi	ician Printed Name	
I hereby give permission for my childto take the above medication at school as ordered. I understand that it is my responsibility to furnish this medication.				
Date	Sig	Signature of Parent/Guardian		
Self-administra Epinephrine fo		ysician and applies to Inhale	er, Insulin or Auto-Injectable	
The following st demonstrated the	udent e capability of self-administerin	has kno ng this medicine. Physician	owledge of this medication and has Must Circle Below	
	Inhaler A	uto-Inject Epinephrine	Insulin	