Oconee County School Health Services

Administration of Medication/Medical Procedures

Student Name_____ Grade/Teacher_____

Date of Birth_____ Telephone_____ ALLERGIES_____

Name of Medication/Medical Procedure_____

Starting Date of Medication/Medical Procedure_____

Time Medication/Medical Procedure is to be provided daily_____

Termination date for administering the Medication/Medical Procedure_____

Physician's requirements of dosage/method of administration

_____

_____

Precautions, possible side effects, interventions _____

_____

In the event that the school has questions regarding medications or problems associate with a medication/procedure, I hereby give permission for school health officials to dialogue with our physician.

Physician Name_____ Physician Phone_____

Date_____

The Oconee County School Health Service department will destroy any medication that is not picked after the medication is discontinued. Prescription medicine should be picked up by the end of the school year, or it will be destroyed.

The nurse has permission to dialogue with school personnel regarding this medication and any related issues.

Medications will be administered according to the directions listed above. I understand that the Oconee County School System and its employees are not liable for adverse effects or injury do to administering (or not administering) the above listed medication/medical procedure.

Date_____ Signature of Parent/Guardian_____

Email _____ Alternate Phone_____

(Rev. 03/10)