

MEDICATION ADMINISTRATION
And EMERGENCY TREATMENT AUTHORIZATION

SCHOOL MEDICATION POLICY

In order for the school to comply with the school committee policy, the following procedure shall be followed when a student takes medication at school.

- 1. Parents must complete this form. If medicine is to be given longer than 10 days (long-term medication) the doctor's signature must be entered on this form.**
- 2. All medicines given by school personnel must have a label including the student's name, the name of the drug, instructions for taking the medication and (when applicable) the doctor's name. Medication must be in the original container.**

I, the undersigned parent or guardian of _____ request the assistance of the First Baptist Church School in administering medication to my child.

I request that medication for my child be kept under the control of the principal, office staff, or homeroom teacher, and that it be made available to my child.

I realize the school can in no way accept any responsibility for the administration of any medication neither to the above named student nor for any condition resulting from the child's failure to procure such medication.

The child and I accept full responsibility for such medication and for the administration of the medication to the child.

Please list any known allergies: _____

PARENTS-Please fill out the following information

Medication	Dosage	Time to be Dispensed	Termination
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Date

Signature of Physician giving authorization to administer medication(s) longer than ten days.

Physician's signature

Signature of Parent or
Guardian _____

Date _____

MEDICAL HISTORY

Please list any special medical information that may affect your child:

Allergies: _____

Medications for long term use _____

Surgeries/major medical procedures _____

History of major illnesses or injury _____

*Has your child had chicken pox? _____ If yes, please give approximate month & year _____

*Has your child had the Chicken Pox Immunization? _____

*Last TB Test given (date) _____ Results _____

Please check the list on the back of this form for emergency medications kept by the school for treatment of minor stings and scrapes. If your child is allergic to any of these, please list them on this page.

I acknowledge that my child's immunizations are current and on file at First Baptist Church School, 600 N. St. Mary's, Beeville Texas.

AUTHORIZATION FOR EMERGENCY FIRST AID AND EMERGENCY TREATMENT

I hereby give permission for emergency first aid treatment with medications kept by the school.

In the event that I cannot be reached to make arrangements for emergency medical treatment for illness or injury, I hereby authorize the teacher or other qualified persons to take my child to

Dr _____ at phone # _____. If not available, to take my child to the hospital emergency room (Christus Spohn Beeville). If you want a different Emergency Room Hospital, please specify.

In case of an emergency in which the parents cannot be reached, please call: (We must have two)

1. _____	_____	_____	_____	_____
Name	Relationship to Child	Home Phone	Cell	Work

2. _____	_____	_____	_____	_____
Name	Relationship to child	Home Phone	Cell	Work

3. _____	_____	_____	_____	_____
Name	Relationship to Child	Home Phone	Cell	Work

Parent or Legal Guardian Signature

Date