Bear Creek
COMMUNITY CHARTER SCHOOL

www.bearcreekschool.com

I want _____to receive the following medication during school hours.

Name of Medication:_____

Dosage:_____

Route of Administration:_____

Time to be Given:_____

Duration of Order:_____

Diagnosis:_____

Physician Signature:_____

Parent/Guardian Authorization

Please check the following:

_____My child is capable of self-administering the above medication under the supervision of the principal, his designee or the school nurse.

_____My child is not capable of self-administering the above medication. I understand that the school nurse will administer this medication.

I relieve Bear Creek Community Charter School and its employees of liability for medication administration and supervision of self-administration.

Parent/Guardian:_____ **Date:**_____

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