BREVARD ACADEMY
1110 HENDERSONVILLE HIGHWAY
PISGAH FOREST, NC 28768
PHONE (828) 885-2665
FAX (828) 862-3497

REQUEST FOR MEDICATION TO BE GIVEN DURING SCHOOL HOURS

PERMISSION TO RELEASE INFORMATION

I give permission for my child's physician to release the following information.

_____
Parent Signature

To be completed by physician
Name of student_____
Medication_____ Dosage _____
(No injection will be given except in extreme emergency, such as allergy to wasp or bee sting.)

Times medication to be given:_____am _____pm _____other
To be given from (date)_____to_____
Significant information: (include side effects, toxic reactions, and omission reactions:)

Contraindications for Administration:_____
If an emergency situation occurs during the school day or if the student becomes ill, school officials are to:
Numbers in preferential order:
_____a. Contact me at my office_____ Phone #_____
_____b. Take child immediately to the emergency room at _____
_____c. Contact parents - Telephone _____
_____d. Other option_____
This medication will be furnished by parent or guardian within a container properly labeled by a pharmicist with identifying information (e.g. name of the child, medication dispensed, dosage prescribed, and the time to be given.)

_____ Date:_____
Phyiscian's Signature DEA # _____

PARENT'S PERMISSION

I hereby give my permission for my child (named above) to receive medication during school hours. I understand that the school undertakes no responsibility for the administration of the medication. This medication has been prescribed by a licensed physician. I hereby release the Board and their agents and employees from any and all liability that may result from my child taking the prescribed medication.
Signature of Parent or Guardian:_____
Date: _____ Telephone Number: _____

(School Use Only)
Name and titles of person to administer medication_____
Approved by_____