COASTAL PLAINS
EDUCATION CHARTER HIGH SCHOOL

Coastal Plains Education Charter High School
Administration of Medicine Form

Student's Name: _____

Date of Birth: _____ Telephone #: _____Drug Allergies: _____

Name of Medication: _____

Starting Date of Medication:_____ Time Medication Taken Daily: _____

Termination date for administering the Medication _____

Physician's requirements of dosage/method of administration:

Precautions, possible side effects, interventions:

In the event the school has questions regarding medication or problems associated with a medicine, I hereby give permission for the school receptionist to dialogue with our physician.

Physician's Name _____ Physician's Phone # _____

Date _____

Coastal Plains Education Charter High School will destroy any medication that is not picked up after the medication is discontinued. Prescription medicine should be picked up within 1 week of discontinuing the medication. Over the counter medicine should be picked up at the end of the school year if the student is not attending school during the summer months.

Medications will be administered according to the directions listed above. I understand that Coastal Plains Education Charter High School and its employees are not liable for adverse effects or injury due to administering (or not administering) the above listed medication(s).

Date: _____ _____

Signature of Parent/Guardian/Adult Student