Beaver County Career and Technology Center
Physician Request for Administration of Medication During School Hours

Student Name:____

Name of Medication:____

Purpose of Medication:____

Dosage:___________________________ Route:_______________________________

Time / Frequency:____

Date to Start:________________________ Date to Stop:__________________________

Special Instructions:____

____

For Asthma Inhalers is student capable of self administration? ______________________

Does the student need to keep inhaler with him/her during school hours?

______ Yes

______ No, it may be kept in the First Aid office.

Physician Signature____________________________________ Date _______________

Print Physician's Name____

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Parent Consent

I hereby request that my child be assisted in taking the above medication as ordered by the physician. In the case of asthma inhalers I authorize the medication to be self-administered by my child if this is approved by the physician. I release the Beaver County Area Career and Technology Center and all its employees from any and all liability for damages my child may suffer as a result of this request.

Signature of Parent/Guardian_____________________________________ Date_________