PENDER COUNTY SCHOOLS

Request for Medication Administration in School

To be completed by physician

Name of Student:_____ School:_____

Medication:_____ Dosage:_____

Time(s) medication is to be given **at school**: a.m._____ p.m._____
Date to be given from: _____ to_____
Significant Information (include side effects, toxic reactions, omission reactions):_____

_____

Contraindications for Administration:_____
_____

If an emergency situation occurs during the school day or if the student becomes ill, school officials are to:

a. Contact me at my office_____ Telephone_____

b. Take child immediately to the emergency room at_____

FOR SELF-ADMINISTRATION -

☐ Student has demonstrated understanding of and ability to self-administer asthma medication, diabetes medication, or medicine for anaphylactic reactions and may carry and self-administer as prescribed.

[Asthma/allergic reaction ☐MDI (*Medicated Dose inhaler) ☐MDI with spacer * ☐Epinephrine auto-injector ☐diabetes –insulin] *Parent/guardian must provide an extra inhaler to be kept at school in case of emergency

A written statement, treatment plan and written emergency protocol developed by the student's health care provider must accompany this authorization form in accordance with requirements stated in G.S. 115C –375.2

Student must have a self-medication treatment agreement/contract.

All prescription medication for use at school will be furnished by parent or guardian in a container properly labeled by a pharmacist and over the counter medicine must be in the original container. All medicines must have identifying information, (e.g., name of child, medication dispensed, dosage prescribed, and the time it is to be given or taken).

_____ _____ _____
Physician's Signature (Print Physician Name) Date

PARENT'S PERMISSION
I hereby give my permission for my child (named above) to receive medication during school hours. This medication has been prescribed by a licensed physician. I hereby release the School Board and their agents and employees from all liability that may result from my child taking the prescribed medication. This consent is good for the school year, unless revoked.

_____ _____ _____
Parent or Guardian's Signature Telephone Number(s) Date

(School Use Only)

Approved by_____ _____
Principal's Signature Date

Reviewed by _____ _____
School Nurse's Signature Date