Bladen County Schools
Request for Medication Administration in School (2020-2021 School Year)

To be completed by healthcare provider:

Name of Student:________________________________ **Date of Birth:** ____________**School:**_______________________

Medication: ____ **Dosage:**____________________________________

Directions: ____

☐ **ROUTINE medication** time(s) to be given: a.m.__________ p.m.__________ **Give with food: Yes or No**

☐ **PRN (As needed) medication given for** ____

Beginning (date) _________________ to **July 31, 2021**

☐ **SHORT TERM routine medication:** Time(s) to be given _____________ from: (date) __________ to ____________

Asthma Inhaler or Epinephrine dose may be repeated (1) time in ______ minutes if no improvement in symptoms.

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 **contact parent** at ____, if unable to reach parent **911 will be called.**

Only Emergency Medications are approved for Self-Administration.

☐ **No, Student may not self carry medication**

☐ **Yes, 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 (Metered Dose inhaler) ☐MDI with spacer ☐Epinephrine or Diabetes: ☐Insulin]

***Parent/guardian is responsible for providing back-up emergency medication to be kept at school in case of emergency. Student must have a self-medication treatment contract also.**

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

All medication for use at school will be provided by parent or guardian in a container properly labeled by a pharmacist with identifying information, (e.g., name of child, medication dispensed, dosage prescribed, and the time it is to be given or taken) or for Over-the-counter medications in the original container.

____ _________________________________

Healthcare Provider Signature Date Healthcare Provider Office Stamp

______________________________ ____

Provider Phone Number Provider Address

*******PARENTAL/GUARDIAN 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 healthcare provider. I hereby give the school nurse consent to discuss this medication with the healthcare provider as necessary to ensure the safety of my child. 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

Accepted by: ____ ____________________________

School Staff Date

School Nurse (sign): ______________________ Date:__________ School Adm. (sign): ____________________ Date: ___________

(03/2020)