



## Request for Medication Administration in School

To be completed by physician

Name of Student: \_\_\_\_\_

School: \_\_\_\_\_

Medication: (each medication is to be listed on separate form) \_\_\_\_\_

Dosage and Route: \_\_\_\_\_

Time(s) medication is to be given: a.m. \_\_\_\_\_ p.m. \_\_\_\_\_ PRN: \_\_\_\_\_

To be given from: (date) \_\_\_\_\_ to/through: \_\_\_\_\_

Significant Information (to include side effects, toxic reactions, reactions if dose is missed, etc.)  
\_\_\_\_\_

Contraindications to 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 ability and understands the use of and may carry/self administer asthma medication, diabetes medication, or medicine for anaphylactic reactions only.**

ASTHMA/ALLERGEN REACTION: MDI (metered dose inhaler) \_\_\_ MDI with spacer\* \_\_\_  
Epinephrine \_\_\_

DIABETES: Insulin \_\_\_ Glucose \_\_\_

\*Parent/guardian must provide an extra inhaler/epinephrine injector/source of glucose to be kept at school in case of emergency and that it will be replaced with it expires.

*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 the requirements stated in G.S. 115c-375.2.*

This order remains in effect for the current academic year only and must be renewed each school year.

Date: \_\_\_\_\_

Physician's Signature \_\_\_\_\_

OVER →

**PARENT'S PERMISSION**

I hereby give my permission for my child \_\_\_\_\_ to receive medication during school hours. This medication has been ordered and 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 one year, unless revoked.

I will furnish all medications for use at school in a container properly labeled by a pharmacist with identifying information, (name of child, medication dispensed, dosage prescribed, and the time it is to be given or taken). All over the counter medications will include the order for administration (first part of this authorization form signed by the doctor) with the identifying information, (name of child, medication dispensed, dosage prescribed according to label, and the time it is to be give or taken), with the medication in the original container.

I will replace this medication when it expires. I will remove this medication from the school the last day of school. I understand medication not picked up will be destroyed after the last day of school.

Parent or Guardian Signature: \_\_\_\_\_

Telephone number(s): \_\_\_\_\_

Emergency contact number in case you cannot be reached: \_\_\_\_\_