

Yancey 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: _____ a.m. _____ p.m. _____

To be given from:(date) _____ to _____

Significant Information (include side effects, toxic reactions, omission reactions):

Contraindications for Administration: _____

In case of an emergency during the school day or if the student become 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 Epi-Pen 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

If self-medicating, student must have a self-medication treatment contract on file.

All prescription medication for use at school will be furnished by parent/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

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/Guardian's Signature

Telephone Number

Date

(School Use Only)

Name and title of person to administer medication (unless self-administered) _____

Approved by _____

Principal's Signature

Date

Reviewed by _____

School Nurse's Signature

Date