

Columbus County Schools
Request for Medication Administration in School

To be completed by physician:

Name of Student: _____ DOB: _____

School/Grade/Teacher _____

Medication: (each medication is to be listed on a separate form) _____

Prescribed for: _____

Dosage and Route: _____

Time(s) daily medication is to be given: a.m. _____ p.m. _____

Time(s) to give PRN(as needed) medication: _____

To be given from: (date) _____ to/through: _____

Significant Information (include side effects, toxic reactions, reactions if omitted, take with/without food, etc.) _____

Contraindications for Administration (reasons not to give): _____

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 _____
print name phone number

b. Take child immediately to the emergency room at _____

FOR SELF-ADMINISTRATION -

Student has demonstrated ability and understands the use of and may carry and self-administer asthma medication, diabetes medication, or medicine for anaphylactic reactions.

[Asthma/allergic reaction MDI (*Metered Dose inhaler) MDI with spacer *

Epinephrine diabetes –insulin diabetes – glucose]

*Parent/guardian must provide an extra inhaler/epinephrine injector/source of glucose 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 **The student also must have a self-medication agreement on file.***

Date _____ Physician's Signature _____

To be completed by parent:

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.

I will furnish all medication 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).

Parent or 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 _____