MEDICATION AUTHORIZATION FORM

SCHOOL: _____ HOME ROOM:_____ GRADE:____ DATE:_____SCHOOL YEAR:_____

Dear Parent/Guardian:
We attempt to discourage administration of medication in the schools. However, if your physician decides it is necessary for your child to receive a medication during the school day, and you are unable to make other arrangements, we must have authorization and specific instructions from child's physician. **Please take this medication form to your physician and have the instructions recorded regarding the administration of your child's medication.** Davie County Schools "Administering *Medication to Students Policy*" #6125 may be found at www.davie.k12.nc.us under Board of Education Policies.

PHYSICIAN'S INSTRUCTIONS FOR GIVING MEDICATION IN SCHOOL

STUDENT'S NAME: _____ BIRTHDATE: _____

In order to keep this student in optimum health and to help maintain maximum school attendance and performance, it is necessary for medication to be given during school hours.

Medication _____ Expiration Date of Med: _____
(include trade name)
Dosage (amount to be given):_____ Location of Med:_____

Medication to be given is circled: Tablet Ointment Capsule Inhalation Liquid Other _____

Relationship to meals? _____

How often or at what time? _____

Side Effects (expected or predictable): _____

Contraindications for Administration: _____

What to do if side effects occur: _____

Student's is Allergic to: _____

_____ _____
Physician's Signature Date

_____ _____
Address Telephone Number

FOR SELF-ADMINISTRATION – PHYSICIAN, PLEASE COMPLETE AND SIGN
The above named student has demonstrated proper technique and understands the use of
***MDI** (Metered Dose Inhaler)☐ **Epi-pen** ☐ **Diabetes:Insulin** ☐ **Other**_____ **and may carry and self-administer this medication for asthma, allergic reaction, diabetes, etc.**
*Parent/guardian are encouraged to provide an extra Inhaler be kept at school in case of emergency.
*Parent/guardian should provide a copy of student's Asthma Action Plan and Peak Flow Meter for use at school.

_____ _____
Physician's Signature **Date**

PARENT/GUARDIAN PERMISSION

I give permission for the exchange of information (verbal, written, or faxed) between the above named health care provider and school nurse from Davie County Schools as needed. I understand that this information will remain confidential.

I request and give permission for the school to administer the above medication prescribed by my child's physician to be given during the school hours. I hereby release the School Board and their agents and employees from any and all liability that may result from the administration of the above medication or students that self-medicate.

I agree to bring/send the medication in a properly labeled container from the pharmacy or original container.

Signed:_____ _____ _____
(Parent or Guardian) **(Date)** **(Telephone Number)**

(Revised 4/12, 1/13, 7/16, 3/17)

Davie County Schools
Student Agreement for Self-Administered Medication

Student's Name	Grade	School	School Year

Parent/Guardian	Telephone Number

Licensed Health Care Provider	Telephone Number

Medication	Dose and Time

Medication is permitted in accordance with Davie County Schools policy. Both student's health care provider and parent/guardian must complete Medication Authorization Form. Student's name must appear on inhaler/container.

STUDENT RESPONSIBLITIES

I plan to keep my inhaler, equipment, Epi-Pen, medication with me at school rather than in the health room or office.

I agree to use my inhaler, equipment, Epi-Pen, medication in a responsible manner, in accordance with my licensed health care provider's orders.

I will notify the school health office or main office if I am having more difficulty than usual with my health condition.

Student's Signature	**Date**

PARENT/GUARDIAN RESPONSIBILITIES

___ Emergency Action Plan complete and on file at school.
___ My son/daughter demonstrates correct use/administration.
___ My son/daughter recognizes proper and prescribed timing for medication.
___ My son/daughter agrees to carry medication or keep in an established location.
___ My son/daughter knows health condition well.
___ My son/daughter keeps a second labeled container in health office or main office.
___ My son/daughter will not share medication or equipment with others.

Comments:

Parent/Guardian Signature	**Date**

School Nurse Signature	**Date**

Davie County Schools and its employees and agents are not liable for any injury arising from a student's self-administration of asthma/allergy medication.

(August 2005)