NEW HANOVER COUNTY
PUBLIC HEALTH
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Phillip Tarte, Director

PHYSICIAN'S AUTHORIZATION FOR MEDICATION AT SCHOOL
School Year 2019-2020

ATTENTION: Please fax completed form to _____(Student's Current School)

Name of Student _____ School _____ Date of Birth _____

Medication _____ Dosage _____ Route _____

Time(s) medication is to be given or how often _____

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

_____

Contraindications for Administration

This medication is to be kept in a locked area and will be provided and transported to and from school by parent or guardian in a container properly labeled by a pharmacist with identifying information (e.g., name of child, medication dispensed, dosage prescribed, route, and the time it is to be given.)

If an emergency occurs during the school day or if the student becomes ill, school officials should call parents, my office or 911.

COMPLETE IF PRESCRIBING MEDICATION FOR ASTHMA, ANAPHYLACTIC OR DIABETIC STUDENTS

Students may possess and self-administer asthma, anaphylactic, or diabetic medication during the school day and/or school activities. Circle **Yes** or **No**

Student has been instructed, states understanding, and demonstrates skills necessary to possess and self-administer medication at school. Circle **Yes** or **No**

For those students who self-administer medication, backup medication must be kept at the school per G.S. 115c-375.2. This student has a written treatment plan.

_____ ( ) _____ _____

Healthcare Provider Signature *Telephone Number* *Date*

PARENT'S PERMISSION

I hereby give 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.

_____ ( ) _____ _____

Parent or Guardian's Signature *Telephone Number* *Date*

Reviewed by: _____ _____

School Nurse's Signature *Date*

STUDENT ACKNOWLEDGMENT OF SELF-ADMINISTERED MEDICATION

I understand and have demonstrated to the school nurse or nurse's designee the skill level necessary to self-administer medication. I agree **not** to share medication or supplies with anyone.

_____ _____

Student's Signature *Date*