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:_____

How often or at what time? _____

Side Effects (expected or predictable): _____

Student's is Allergic to: _____

_____ _____ _____ _____

Physician's Signature **Address** **Telephone Number** **Date**

FOR SELF CARRY / SELF-ADMINISTRATION – PHYSICIAN, PLEASE COMPLETE AND SIGN
The above named student has demonstrated proper technique and understands the use of and may carry and self-administer this medication for asthma or allergic reaction, or diabetes. (Inhaler, Epi Pen, and Diabetic Medication / Supplies)

_____ _____
Physician's Signature **Date**

STUDENT RESPONSIBILITIES

- I will be responsible for the location of the above listed medication and related supplies while at school.
- I agree to use the above listed medication and related supplies 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 PERMISSION

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

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)**

Signed:_____ _____ _____

(Parent or Guardian) **(Date)** **(Telephone**

(Form Revised April 2012)