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.godavie.org 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.

_____ Expiration Date of Med:

Medication _____

(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/Date **Address** **Telephone Number**

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.

Signed:_____ _____

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

_____

(Telephone #)