Student Name: _____

Grade: _____ Teacher: _____

School: _____

School Phone: _____

School Fax: _____

REQUEST FOR ADMINISTRATION OF MEDICATION TO STUDENT

Dear Parent/Guardian:

Under certain conditions, as service to you and for the welfare of your child, parental requests for the in-school administration of necessary prescribed and/or over-the-counter medication/health procedures will be honored. This request is filled out individually for each medication required to be given during school hours and renewed at least annually. This parental request also gives the school permission to contact the prescribing provider as necessary. **Please note**: "Medication" refers to any prescription, non-prescription, homeopathic, herbal, vitamin, or mineral preparation.

Medications MUST:

◍ Be in original pharmacy container ◍ Brought to school by parent/guardian,other responsible adult,or the pharmacy

Medications MUST have a label showing the following:

◍ Student's Name ◍ Name of medication ◍ Dosage ◍ Frequency ◍ Doctor's Name ◍ Pharmacy Name ◍ Date Issued ◍ Prescription Number ◍ Expiration Date

The written statement below, signed and dated by the attending physician, supporting this signed parental request is required prior to medication being given. The physician's statement must also provide clear direction for administering the medication or health procedure in school. If the medication must be given at a certain time per the physician orders, the staff has a 30 minute window before and after the ordered time to administer the medication.

PARENT

As indicated by the prescribing physician below, I do hereby request and authorize that the prescribed or over-the-counter medication/health procedure be administered to:

Student Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Parent/Guardian Name (printed): _____

Parent/Guardian Signature: _____ Date: _____

PHYSICIAN

I recommend that the prescribed or over-the-counter medication/health procedure listed below be administered to:

Student Name: _____ Date of Birth: _____

Diagnosis: _____

Name of Medication/Health Procedure: _____

Dosage: _____ Time/Frequency: _____

Give Medication **BEFORE LUNCH:** yes/no **After Lunch:** yes/no

Route of Administration: _____

First Date of Administration: _____ Last Date of Administration: _____

Additional Directions/Precautions (please note reason to administer if P.R.N dose): _____

_____

Physician Address: _____

Physician Phone Number: _____

Physician Name (printed): _____

Physician Signature: _____ Date: _____

Imprint Physician Office Stamp Below:

LETTER TO PARENTS REGARDING ADMINISTRATION OF MEDICATION IN SCHOOL

Dear Parents,

We are aware and thankful for your trust in us as we serve and care for your children on a daily basis. In regards to the administration of medication, please know that we are bound by certain regulations to keep all of our students safe.
ALL MEDICATIONS MUST BE KEPT IN THE FRONT OFFICE

If your child must have medications of any type, including over-the-counter drugs, given during school hours, you have the following choices:

1. You may come to the school and give the medication to your child at the appropriate time(s).

2. You may obtain a copy of the medication form from the school secretary. Take the form to your child's doctor and have him/her complete the form by listing the medication(s) needed, dosage, and number of times per day the medication is to be administered. This form must be completed by the physician for both prescription and over-the-counter drugs. The form must be signed by the doctor and by you, the parent or guardian. Prescription medicines must be brought to school in a pharmacy-labeled bottle which contains instructions on how and when the medication is to be given. Over-the-counter drugs must be receive in the original container and will be administered according to the doctor's written instructions.

3. You may discuss with your doctor an alternative schedule for administering the medication (i.e. outside of school hours).

4. Self-medication: In accordance with G.S. 115C-375.2 and G.S. 115C-47, students requiring medication for asthma, anaphylactic reactions (or both), and diabetes may self-medicate with physician authorization and a medication form filled out by the doctor.
   ALL MEDICATIONS MUST BE KEPT IN THE FRONT OFFICE

5. Please have physician fill out an emergency action plan for children needing an epi-pen, asthma medications, or seizure medications. We also need a plan of care for children with diabetes signed by the physician.

School personnel will not administer any medication to students unless they have received a medication form properly completed and signed by both doctor and parent/guardian, and the medication has been received in the original labeled container.

If you have any questions related to the administration of medications in the school, please contact the office at 586-791-3500

Thank you,