

ONSLOW COUNTY SCHOOLS STUDENT HEALTH SERVICES
Permission for Prescribed Medication to Be Given During School Hours

TO BE COMPLETED BY PARENT/GUARDIAN:

Date: _____ School: _____ Teacher/Grade: _____

Name of Student: _____ Date of Birth: _____

I hereby give consent for the school staff to administer this medicine to my child according to the physician's following directions. The school nurse has my permission to contact the physician should there be any questions or concerns regarding the medication.

I understand that medicine will be delivered to school personnel by a parent/guardian and that **students are not to transport medications.****

I understand that this prescribed medicine will be in the **original pharmacy labeled container** with identifying information (e.g., name of child, medication name, dosage prescribed, and time of administration)

If this is an **over the counter medication**, the medication must be in the original, labeled container.

I hereby release the School Board and their agents and employees from any and all liability that may result from my child taking this prescribed medication and from any and all liability that may result from my child's self-medication.

Parent/Guardian(Print) _____ Signature _____

Date _____ Home# _____ Cell# _____ Work# _____

TO BE COMPLETED BY PRESCRIBING PHYSICIAN:

To help this student maintain school performance, it is necessary that the medication below be given during school hours.

Medication _____ Strength _____ Dosage _____ Route: _____

Time(s) medication to be given at school: a.m. _____ p.m. _____

As Needed/PRN _____ *Circumstance: _____

*(If medication is ordered as needed, please indicate specific circumstances when medication should be given. Non-medical personnel may be administering the medication.)

Beginning date: _____ Ending date: _____

Reason for medication: _____ Possible side effects: _____

Known medication allergies _____ Contraindications for Administration: _____

EMERGENCY MEDICATIONS:

For **emergency medications, student may/may not (circle one) self-medicate.

**If this is an emergency medicine, I certify that the student has been instructed by me in its proper use and needs to carry it at all times. Yes _____ No _____ N/A _____

For students with asthma: ** The student has an Asthma Action Plan. Yes _____ No _____

**The student uses/has a Peak Flow Meter. Yes _____ No _____

Physician's Name (Stamp) _____ Phone# _____

Physician's Signature _____ Date _____

**THIS FORM MUST BE RENEWED AT THE BEGINNING OF EACH SCHOOL YEAR
 AND WHENEVER THERE IS ANY CHANGE IN THE MEDICATION.**

Nurse Signature _____ Date _____

Dear Parent:

Our school has a written policy to assure the safe administration of medication to students during the school day. If your child must have medication of any type given during school hours, including over-the-counter medicines, you have the following choices:

1. You may come to school and give the medication to your child at the appropriate time(s).
2. You may obtain a copy of a medication form from the school nurse or 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 medications 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 received 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 medication (i.e., outside of school hours).

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 an appropriately labeled container. To protect the safety of your child and in fairness to those giving the medication, there will be no exceptions to this policy.

Children may carry rescue inhalers and other emergency medications with the permission of the physician and parent/guardian. Please ensure your child is familiar with correct administration and dosage of the emergency medications they are using.

Any prescription changes in dosage, times to be given, or methods of administration must be accompanied by a new permission form signed by both physician and parent/guardian.

If you have any questions about issues related to the administration of medication in the schools, please contact the school nurse.

Thank you for your cooperation.