CHAPEL HILL-CARRBORO CITY SCHOOLS

REQUEST FOR ADMINISTRATION OF MEDICINES

Student Name:	**Date of Birth:**
School:	**Teacher/Team/Grade:**

To be completed by authorized Health Care Provider (HCP)licensed to prescribe in NC

Medication:

Dose:_____ **Route:**_____ **Time(s):**_____

Start Date:_____**Termination date :**_____ **(if no date entered, effective for 1 year)**

Purpose of medication:

Side effects/contraindications:

Some medications may be self-administered at school and/or on a field trip, if appropriate I consider this student to have the maturity and knowledge to self administer his/her medication ▫ **Yes** ▫ **No**

Health Care Provider	(signature)	(print)
	(phone)	(email)

To be completed by parent/guardian

I hereby give permission for my child to receive medication in accordance with CHCCS policy 6125, Administering Medicine to Students. All medications, including over-the-counter products, have been prescribed under the authority of a licensed HCP(s). Medications will be furnished in current pharmacy-labeled bottles with identifying information and brought to school by parent/guardian. I assume full responsibility for informing the school of any change in my child's health and/or medication. I agree that medication dosage cannot be changed without a physician's order. Further, I understand that the only responsibility or liability that can be assumed by the school system or its personnel is to comply with the instructions provided by the child's parent and physician.

Parent/Guardian	(signature)	(print)
	(phone)	(email)

Note: *I understand some emergency medications may be self carried and administered. Additionally scheduled medication may be self-administered under supervision while traveling out of state on a field trip. If appropriate, I consider my student to have the maturity and knowledge to self-administer his/her medication and understand that the school system can assume no liability for monitoring the self-administration* ▫ **Yes** ▫ **No**

To be completed by school nurse

School Nurse:	**Date Received:**