Form A

**PAMLICO COUNTY SCHOOLS**

**AUTHORIZATION OF MEDICATION FORM**

**TO BE COMPLETED BY PHYSICIAN/MEDICAL PROVIDER**

Date: _____ Date of Birth: _____

Name of Student: _____

School: _____

In order to keep this student in optimum health and to help maintain school performance, it is necessary that medication be given during school hours.

Medication: _____ Dosage/mg _____ Route _____

Significant information: _____

Time(s) medication is to be given at SCHOOL: _____

* Providers please note that “lunch time” can vary from 10:30 AM to 1:30 PM.

For asthma inhaler, insulin or Epi-pens users:

- ☐ May self-medicate (student has demonstrated proficient use of medication).
- ☐ May not self-medicate.

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If medication is ordered as needed, please indicate specific circumstances when medication should be given (School staff, not licensed medical or nursing personnel, will be administering medication):

_____
Medical Provider’s Signature

_____ _____
Print Medical Provider’s Name Telephone number

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**TO BE COMPLETED BY PARENT**

I hereby give permission for my child, _____, to receive medication during school hours. This medication has been prescribed by a licensed physician. I hereby release the School Board and their agents and employees from any and all liability that may result from my child taking the medication.

_____
Signature of Parent/Guardian

_____/_____
Telephone number / Date