

AUTHORIZATION FORM FOR ADMINISTERING MEDICATIONS AT SCHOOL

Employees and agents of Dare County Schools are authorized to administer medications only when the following conditions have been met:

1. The student's parents or legal custodian has made a written request that school personnel administer the medication to the student and has given explicit written instructions describing the manner in which the medication is to be administered;
2. A healthcare provider has prescribed the medication for use by the student;
3. A healthcare provider has certified that administration of the medication to the student during the school day is necessary;
4. The employee or agent administers the medication pursuant to the written instructions provided by the student's parent or legal custodian.

Student _____ DOB _____ School _____ Grade _____

Parent/Guardian _____ Primary Phone _____ Secondary Phone _____

To be completed by Parent/Guardian:

I hereby give permission for _____ to receive _____
(Student's Name) (Name of medication and dose)
during school hours. Generic equivalents may be substituted. Prescription medications must be sent in the original container(s) with the student's identifying information and specific written directions as to conditions prescribed for, dosage, and time of administration. Please list specific instructions (condition prescribed for, time of administration, & side effects):

I hereby give permission to authorized school personnel to administer the medications listed above during school hours pursuant to written directions. I hereby release the Dare County School Board, their agents and employees from all liability that may result from my child taking the medication. My signature indicates I have read and understand Policy 6125 Administering Medicines to Students.

If an emergency occurs during the school day, involving this diagnosis or medication, school personnel are to:

Parent/Guardian Signature

Date

To be completed by Physician/Health Care Provider for Prescription and Over-the-Counter meds:

Medication _____ Dosage _____ Route _____ Time _____

Medication _____ Dosage _____ Route _____ Time _____

Contraindications for administration _____

The following permission may be given for inhalers, insulin or epinephrine auto-injectors:

() This student has been instructed, has demonstrated, and understands the proper use of his/her ***inhaler, insulin or epinephrine auto-injector*** & he/she should be allowed to carry it with him/her.

() This student should not carry his/her ***inhaler, insulin or epinephrine auto-injector*** with him/her.

By signing below, I certify that administration of this medication during the school day is necessary to maintain and support the student's continued presence in school.

Physician/Provider Signature

Date