

Front (doctor) and back (parent) must be completed. Incomplete forms will NOT be accepted.

Student: \_\_\_\_\_ DOB: \_\_\_\_\_ School Year: \_\_\_\_\_

| Daily or PRN Medications                                                           |            |        |       |                 |
|------------------------------------------------------------------------------------|------------|--------|-------|-----------------|
| (one daily medication and/or PRN medication order per sheet)                       |            |        |       |                 |
| Daily and PRN medications MAY NOT be self-administered or self-carried by students |            |        |       |                 |
| Diagnosis                                                                          | Medication | Dosage | Route | Time(s) to give |
| Daily medication for:                                                              |            |        |       |                 |
| PRN medication for:                                                                |            |        |       |                 |

  

| Emergency Medications                                                                                                                                                                                                       |                                                                                                                                                                                                                                  |                                                                                                                                                                                                 |                                                                                                                                        |                                                                                                                                                                                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| (may order multiple medications per sheet)                                                                                                                                                                                  |                                                                                                                                                                                                                                  |                                                                                                                                                                                                 |                                                                                                                                        |                                                                                                                                                                                                |
| Physician Authorization for Student to Self-Administer Emergency Medication <input type="radio"/> Yes <input type="radio"/> No                                                                                              |                                                                                                                                                                                                                                  |                                                                                                                                                                                                 |                                                                                                                                        |                                                                                                                                                                                                |
| Adult supervision is NOT needed. The student has been instructed in the treatment plan, self-administration for the listed medication(s), and has demonstrated the skill level necessary to self-administer the medication. |                                                                                                                                                                                                                                  |                                                                                                                                                                                                 |                                                                                                                                        |                                                                                                                                                                                                |
| Diagnosis                                                                                                                                                                                                                   | Medication                                                                                                                                                                                                                       | Dosage                                                                                                                                                                                          | Route                                                                                                                                  | Time(s) to give                                                                                                                                                                                |
| Allergic to:                                                                                                                                                                                                                | <input type="radio"/> Diphenhydramine<br><input type="radio"/> Other:                                                                                                                                                            | <input type="radio"/> 12.5 mg<br><input type="radio"/> 25 mg<br><input type="radio"/> Other:                                                                                                    | By Mouth                                                                                                                               | <input type="radio"/> Upon Exposure<br><br><input type="radio"/> Mild Reaction                                                                                                                 |
| Allergic to:                                                                                                                                                                                                                | Epinephrine Auto Injector                                                                                                                                                                                                        | <input type="radio"/> 0.15 mg<br><br><input type="radio"/> 0.3 mg                                                                                                                               | Intramuscular                                                                                                                          | <input type="radio"/> Upon Exposure<br><input type="radio"/> Severe reaction or more than 1 mild symptom<br><input type="radio"/> If provided, repeat dose after 5 min. for continued symptoms |
| Seizures                                                                                                                                                                                                                    | <input type="radio"/> Diazepam<br><input type="radio"/> Midazolam:<br><input type="radio"/> Other:                                                                                                                               | <input type="radio"/> 5.0 mg<br><input type="radio"/> 7.5 mg<br><input type="radio"/> 10.0 mg<br><input type="radio"/> 15.0 mg<br><input type="radio"/> 20.0 mg<br><input type="radio"/> Other: | <input type="radio"/> Intranasal<br><input type="radio"/> By Mouth<br><input type="radio"/> Buccal<br><input type="radio"/> Rectal     | <input type="radio"/> At onset of seizure<br><input type="radio"/> Seizure > 5 min.<br><input type="radio"/> Seizure > 10 min.<br><input type="radio"/> Other:                                 |
| Diabetes                                                                                                                                                                                                                    | <input type="radio"/> Glucagon:<br><input type="radio"/> Other:                                                                                                                                                                  | <input type="radio"/> 0.5mg<br><input type="radio"/> 1.0mg<br><input type="radio"/> 3.0mg                                                                                                       | <input type="radio"/> Intramuscular<br><input type="radio"/> Subcutaneous<br><input type="radio"/> Intranasal<br><input type="radio"/> | If student is unable to safely swallow or becomes unconscious                                                                                                                                  |
| Asthma: Yellow Zone                                                                                                                                                                                                         | <input type="radio"/> Albuterol<br><input type="radio"/> Other:                                                                                                                                                                  | <input type="radio"/> 2 puffs<br><input type="radio"/> 4 puffs                                                                                                                                  | <input type="radio"/> Inhaler<br>w/spacer if provided                                                                                  | <input type="radio"/> Every 4 hrs. as needed to relieve symptoms.<br><input type="radio"/> Other:                                                                                              |
| Asthma: Red Zone<br>Call 9-1-1 and Parent                                                                                                                                                                                   | <input type="radio"/> Albuterol<br><input type="radio"/> Other:                                                                                                                                                                  | <input type="radio"/> 4 puffs                                                                                                                                                                   | <input type="radio"/> Inhaler<br>w/spacer if provided                                                                                  | For emergency symptoms<br><input type="radio"/> May repeat every 20 min. x 3 doses                                                                                                             |
| Asthma: Additional instructions if needed                                                                                                                                                                                   | <input type="radio"/> Albuterol<br><input type="radio"/> Other:                                                                                                                                                                  | _____ puffs                                                                                                                                                                                     | <input type="radio"/> Inhaler<br>w/spacer if provided                                                                                  | When to give:                                                                                                                                                                                  |
| Asthma: <input type="radio"/> Symbicort<br><input type="radio"/> Dulera                                                                                                                                                     | <b>Yellow Zone:</b> 1 puff inhaled every 5 min as needed for cough, wheeze, SOB, up to 4 puffs. Call parent/guardian if not improved after 4 puffs<br><b>Red Zone:</b> Call 911. Give 1 puff inhaled every 5 min. up to 12 puffs |                                                                                                                                                                                                 |                                                                                                                                        |                                                                                                                                                                                                |

**I CERTIFY THAT ADMINISTRATION OF THE PRESCRIBED MEDICATION(S) TO THE STUDENT DURING THE SCHOOL DAY IS NECESSARY TO MAINTAIN AND SUPPORT THE STUDENT'S CONTINUED PRESENCE IN SCHOOL OR AT SCHOOL SPONSORED EVENTS.**

Physician/HCP Signature: \_\_\_\_\_ Name (printed): \_\_\_\_\_

Date: \_\_\_\_\_ Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

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Student: \_\_\_\_\_ DOB: \_\_\_\_\_ School Year: \_\_\_\_\_

**Parent/Guardian:**

I understand that:

- Only emergency, diabetes care and cystic fibrosis medications may be self-administered and/or self-carried
- Non-medical personnel may conduct the medication administration.
- It is my responsibility to have an adult transport the medication to school.
- Medication must be provided in the original pharmacy labeled container with directions for administration. If medication is available over-the-counter, it must be provided in the original container/package, labeled with the student's name.
- Unused medications not picked up by the end of school year will be discarded.
- If medication is not available at the school, 9-1-1 will be called for emergencies.
- If my child participates in NCPS before/after-school sponsored activities/sports, I will assume responsibility for contacting the advisor/coach of my child's medical condition. I will provide extra emergency medications that may be needed during the activity. I may contact the school nurse if assistance is needed in instructing the advisor in a medical procedure or if a copy of the information needs to be shared with them.

I request that:

- My child be administered the medication(s) as indicated in the healthcare provider's orders.
- If an emergency injection is ordered, I give permission for the school nurse to instruct designated staff in the administration technique.

I authorize:

- The release and exchange of medical information between my child's healthcare provider, school nurse, and the Nash County Public School System that is necessary in carrying out services for my child.

I hereby give permission:

For my child to receive medication during school hours. A licensed healthcare provider has prescribed the medication.

If self-administration/carry is prescribed: I give permission for my child to carry and administer the emergency medication listed on the reverse side during the school day, at school-sponsored activities, or while in transit to or from school. Adult supervision is not needed and I understand that:

- I will provide back-up medications to be kept at the school (in addition to what my child will carry) \_\_\_\_\_ *parent initials*
- My child will be required to demonstrate the skill level necessary to self-administer the medication. \_\_\_\_\_ *parent initials*
- My child will be subject to disciplinary action if medication is used in any manner other than prescribed. \_\_\_\_\_ *parent initials*

I hereby release the Nash County Public Schools Board of Education and their agents and employees from any and all liability that may result from my child taking the prescribed medication.

Parent/Guardian Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Date: \_\_\_\_\_

**Student: self-carry/administer authorized**

I will keep my medication and equipment with me at school and school-sponsored activities.

I will *only* use the medication as prescribed by my healthcare provider.

My medication will be kept in the original container labeled with my name.

I will *not* allow any other person to use my medication.

I will notify a school staff member if I am having more difficulty than usual with my health condition.

Student signature: \_\_\_\_\_ Date: \_\_\_\_\_

I have observed the student verbalize and demonstrate the knowledge, ability, and skill level necessary to use the medication as prescribed by the healthcare provider. Circle: Inhaler    Epinephrine Auto Injector    Cystic Fibrosis Medication

Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Nurse Signature: \_\_\_\_\_ Date received and reviewed: \_\_\_\_\_