Hertford County Public Schools
Authorization for Medication Administration in School

TO BE COMPLETED BY PHYSICIAN

Name of Student:_____ School:_____

Medication:_____ Dosage:_____

Purpose of
Medication:_____

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

To be given from: August 1, (year) _____ to July 31, (year) _____

Significant Information (include side effects, toxic reactions, omission reactions):_____
_____

Contraindications for Administration:_____
_____

If an emergency situation occurs or if the student becomes ill, school officials are to:

a. Contact me at my office_____ Telephone_____

b. Take child immediately to the emergency room at_____

FOR SELF-ADMINSTRATION ONLY -

☐ Student has demonstrated understanding of and ability to self-administer asthma medication, diabetes medication, or medicine for anaphylactic reactions and may carry and self-administer as prescribed.

[Asthma/allergic reaction ☐MDI (*Medicated Dose inhaler) ☐MDI with spacer * ☐Epinephrine auto-injector ☐diabetes –insulin] *Parent/guardian must provide an extra inhaler to be kept at school in case of emergency

Student must have a self-medication treatment agreement.

All medication for use at school will be furnished by parent or guardian in a container properly labeled by a pharmacist with identifying information, (e.g., name of child, medication dispensed, dosage prescribed, and the time it is to be given or taken).

_____ _____
Physician's Printed Name Office Phone Number

_____ _____
Physician's Signature Date

PARENT'S PERMISSION

I hereby give my permission for my child (named above) to receive medication at school. This medication has been prescribed by a licensed physician. I hereby release the School Board and their agents and employees from all liability that may result from my child taking the prescribed medication. This consent is good for the school year, unless revoked.

_____ _____ _____
Parent or Guardian's Signature Telephone Number Date

(Please complete the Student Agreement for Self-Carried Medication information on the back of this page
If student will be carrying medication at school)

Hertford County Public Schools
Student Agreement For Self-Carried Medication

Student: _____ Grade:_____ School:_____

Parent:_____ Telephone Number:_____

Licensed Health Care Provider:_____ Telephone Number:_____

Medication:_____ Dose and Time:_____

Medication is permitted in accord with district policy. Both student's health care provider and parent/guardian must complete Medication Authorization Form. Student's name must appear on inhaler/container and/or supplies.

RESPONSIBILITIES

I plan to keep my inhaler, equipment, diabetic supplies and/or Epinephrine auto injector with me at school.

I agree to use my inhaler, equipment, diabetic supplies and/or Epinephrine auto injector in a responsible manner, in accordance with my licensed health care provider's orders.

I will notify the school staff (i.e., teacher, nurse) if I am having more difficulty than usual with my health condition.

I will not allow any other person to use my inhaler, equipment, diabetic supplies, and/or Epinephrine auto injector. If I use the medication in a manner other than as prescribed, the school may impose disciplinary action according to the school's disciplinary policy.

Student's signature:_____ Date:_____

_____ Emergency Action Plan complete and on file at school.
_____ Demonstrates correct use/administration.
_____ Recognizes proper and prescribed timing for medication.
_____ Agrees to carry medication or keep in established location.
_____ Knows health condition well.
_____ Keeps a second labeled container in health office or main office.
_____ Will not share medication or equipment with others.

Comments:_____

_____

School Nurse Signature:_____ Date:_____