



Medication Administration Permission Form

10A NCAC 09 .0803 (centers) and .1720 (family child care homes)

Parent/guardian completes, signs, and dates the Medication Administration Permission Form. The person accepting this form must attach the Medication Administration Record(s) to this form.

Permission valid from date:	To date:
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Only complete this section if the medication is for a child who has a chronic medical condition or an allergy

☐ This document is written permission to administer this medication for up to 6 months. Specific chronic medical or allergic condition:

Child has an: ☐ Medical Action Plan (required)

Child's Full Name:	Date of birth:
Medication name:	Expiration date:

When to give medication (choose one):

☐ Give medication on these specific dates and times:
☐ Give medication as needed. List the specific symptoms or circumstances needed to give the medication and how often it can be given. Ex. <i>If Suzy has a rash and is scratching it, apply this ointment to the rash, Wait at least 6 hrs before reapplying.</i>

Dosage (how much medication to give):
Route (how to give the medication):
Special instructions on how to give medication:
Possible reactions or side effects:
☐ Child has received at least one dose of medication at home without reactions or side effects.

Prescribing health care professional name:	Phone:
Pharmacy:	Phone:

I give authorization to give medicine and to call the prescribing health care professional or pharmacy if needed

Parent/guardian name:	
Parent/guardian signature:	Date

Medication Dispensing tracking is entered into Infinite Campus



Weldon City Schools

RECEIPT OF MEDICATION DELIVERED TO SCHOOL

Student Name: _____ DOB: _____
Teacher: _____ Grade: _____

INITIAL MEDICATION DELIVERY

Name of Medication: _____

Date: _____ Dosage: _____ Time to be given: _____

☐ Healthcare Provider Order Received

☐ Parent Permission Received

Number of Pills Received (if count is appropriate): _____

School Nurse Signature: _____

Parent / Guardian Signature: _____

SUBSEQUENT MEDICATION DELIVERY

Date: _____ **Number of Pills Received (if count is appropriate):** _____

School Nurse Signature: _____

Parent / Guardian Signature: _____

Date: _____ **Number of Pills Received (if count is appropriate):** _____

School Nurse Signature: _____

Parent / Guardian Signature: _____

Date: _____ **Number of Pills Received (if count is appropriate):** _____

School Nurse Signature: _____

Parent / Guardian Signature: _____

Date: _____ **Number of Pills Received (if count is appropriate):** _____

School Nurse Signature: _____

Parent / Guardian Signature: _____