SCHOOL HEALTH SERVICES
Orange County Schools
200 East King Street
Hillsborough, NC 27278

MEDICATION AUTHORIZATION

HEALTH CARE PROVIDER: COMPLETE ALL ITEMS IN BOLD

Student Name _____ **Date of Birth** ____/____/____
School _____ Phone _____ Fax _____
Medication _____ **Dosage** _____ **Route** _____ **Frequency** _____
Time(s) to be given _____ **Dates to be given from** ____/____/____ **to** ____/____/____
(Medication authorization will be in effect for one calendar year unless otherwise specified.)
Purpose of medication _____
Side effects/contraindications _____

Some medications may be self-administered at school and/or on a field trip. If appropriate, I consider this student to have the maturity and knowledge to self-administer their medication. ____ **Yes** ____ **No**

Health Care Provider's Signature _____ **Date** ____/____/____

Health Care Provider's Name/Title (print) _____ **Phone** _____

PARENT/GUARDIAN PERMISSION

I hereby give my permission for my child (named above) to receive medication in accordance with OCS policy 6125, *Administering Medicines to Students*. All medications, including over-the-counter products, have been prescribed by a licensed health care provider. Medications will be furnished in current pharmacy-labeled bottles with identifying information and brought to school by parent/guardian. I assume full responsibility for informing the school of any change in my child's health and/or medication. I agree that medication dosage cannot be changed without a licensed health care provider's order. Further, I hereby release the School Board and their agents and employees from all liability that may result from my child taking the prescribed medication.

NOTE: I understand some emergency medications may be self-carried and administered. Additionally, scheduled medication may be self-administered under supervision while traveling on a field trip. If appropriate, I consider my student to have the maturity and knowledge to self-administer their medication and understand that the school system can assume no liability for monitoring the self-administration. I assume the responsibility for ensuring that my child is carrying and taking their medication as ordered. Prior to acceptance of a self-administered medication on campus, the school nurse must ascertain the student's maturity and knowledge, as well as review/ensure compliance with OCS protocol. Schools may revoke this privilege if the student proves to be irresponsible or incapable. With these facts in mind, **I give permission for my child to self-administer medication**: ____ **Yes** ____ **No**

Parent/Guardian Signature _____ **Phone** _____ **Date** ____/____/____

SCHOOL USE ONLY

School Nurse Signature _____ **Date** ____/____/____

Medication Sign In & Sign Out Log				
Date	**Medication**	**Amount Received**	**Received by (signature)**	**Received from (signature)**

Drug Disposal Method

____ Remainder of medication retrieved Date _____ Initials _____
____ N/A (no medication supply remains) Date _____ Initials _____
____ Discarded per OCS procedure Date _____ Initials _____

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Purpose of medication _____
Side effects/contraindications _____

Some medications may be self-administered at school and/or on a field trip. If appropriate, I consider this student to have the maturity and knowledge to self-administer their medication. ____ Yes ____ No

Health Care Provider's Signature _____ **Date** ____/____/____
Health Care Provider's Name/Title (print) _____ **Phone** _____

PERMISO DE PADRE/TUTOR

Por la presente doy mi permiso para que mi hijo (nombrado arriba) reciba medicamentos de acuerdo con la política 6125 de OCS, administrando medicamentos a los estudiantes. Todos los medicamentos, incluidos los productos de venta libre, han sido recetados por un proveedor de atención médica con licencia. Los medicamentos se suministrarán en las botellas actuales con la etiqueta de la farmacia con información identificativa y lo traiga al escuela el padre/tutor. Asumo toda la responsabilidad de informar a la escuela de cualquier cambio en la salud y/o medicación de mi hijo. Estoy de acuerdo en que la dosificación de la medicación no puede ser cambiada sin la orden de un proveedor de atención médica con licencia. Además, por la presente libero a la junta escolar y a sus agentes y empleados de toda responsabilidad que pueda resultar de que mi hijo tome el medicamento recetado.

Nota: entiendo que algunos medicamentos de emergencia pueden ser auto-transportados y administrados. Además, la medicación programada puede ser autoadministrada bajo supervisión mientras viaja en un viaje de campo. Si es apropiado, considero que mi estudiante tiene la madurez y el conocimiento para autoadministrarse su medicación y entender que el sistema escolar no puede asumir ninguna responsabilidad por el monitoreo de la auto-administración. Asumo la responsabilidad de asegurar que mi hijo/a lleve y tome su medicación según lo ordenado. Antes de la aceptación de un medicamento autoadministrado en el campus, la enfermera de la escuela debe determinar la madurez y conocimiento del estudiante, así como revisar/asegurar el cumplimiento del Protocolo de OCS. Las escuelas pueden revocar este privilegio si el estudiante resulta ser irresponsable o incapaz. Con estos hechos en mente, **doy permiso para que mi hijo/a autoadministrarse la medicación**: **____ Sí ____ No**

Firma del padre/tutor _____ **Teléfono** _____ **Fecha** ____/____/____

SCHOOL USE ONLY

School Nurse Signature _____ **Date** ____/____/____

Medication Sign In & Sign Out Log				
Date	**Medication**	**Amount Received**	**Received by (signature)**	**Received from (signature)**

Drug Disposal Method

____ Remainder of medication retrieved Date _____ Initials _____
____ N/A (no medication supply remains) Date _____ Initials _____
____ Discarded per OCS procedure Date _____ Initials _____

ORANGE COUNTY SCHOOLS –
MEDICATION AUTHORIZATION FOR SELF-ADMINISTRATION

Self-Administration Protocol

1. The health care provider, parent/legal guardian, and student must complete and sign the *Medication Authorization Form* on an annual basis.
2. The school nurse, in consultation with the principal, is the final judge of the student's compliance with these guidelines in the school.
3. Self-administration of medication shall comply with OCS Policy 6125 and accompanying procedure.
4. The student must demonstrate sufficient maturity and knowledge to use the mediation safely and correctly.

Student Section

My health care provider, parent/legal guardian, and I agree that I have sufficient maturity and knowledge to use the medication (named on this form) safely and correctly. I agree to:

- ➔ have my medication readily available with the help of my parent/legal guardian
- ➔ keep the medication in my possession at all times and not leave it in a place accessible to other students, nor allow or offer any use to other students
- ➔ use medication in a responsible manner, in accordance with my health care provider's orders
- ➔ notify the school office or school nurse if I am having more difficulty than usual with my health condition

Student Signature _____ **Date** ____/____/____

SCHOOL NURSE USE ONLY

Review with Student

_____ Demonstrates correct use/administration of medication
_____ Recognizes need for and proper timing of medication as prescribed by health care provider
_____ Identifies a proper location and method to carry medication
_____ Knows health condition well
_____ Keeps a second labeled container in med cart or Health Office (as indicated)
_____ Review *Emergency Action Plan* (as indicated)

Final Consent to Allow Self-Administration of this Medication

_____ Self-administration is not an option for this student or this medication
_____ Self-administration under supervision may occur on field trips
_____ Self-administration is appropriate for this student and this medication

School Nurse Signature _____ **Date** ____/____/____