STUDENT HEALTH SERVICES

Authorization/Request for Medication Administration in School

Rev: June 2026

Please Note: This medication consent is effective for one school year and must be renewed annually.

To be completed by Health Care Provider:

NAME OF STUDENT: _____ DOB: _____ SCHOOL: _____

MEDICATION: _____ DOSAGE: _____

Time/When Medication is to be Given: _____ School year : _____

Effective date: From (date) _____ to _____

Special comments or instructions: _____

EMERGENCY MEDICATIONS: *(Please complete if prescribing medications for Asthma, Anaphylactic, or Diabetic students).*

____ YES ___ NO Student may possess and self administer ASTHMA medications during the school day, at school sponsored activities, on the bus, or on other school property.

____ YES ____ NO Student may possess and self-administer an EPI-PEN Auto Injector or Neffy Spray during the school day, at school sponsored activities, on the bus, or on other school property.

____ YES ____ NO **The student understands or has been instructed on self administration of their emergency medication and has demonstrated the skill level necessary to use the medication and any device necessary to administer the medication.**

Date: _____

Physician's Name: _____

Physician's Signature: _____

Physician's Phone: _____

DEA# _____

Office Stamp:

To be Completed by the Parent/Guardian:

- *I hereby authorize the school nurse to confer with the licensed prescriber and correspond with the indicated agency regarding my child's health and treatment issues as they pertain to the medication/diagnosis and his/her attendance, education, and behavior management.*
- *I understand that the medicine prescribed will be provided to the school in the original pharmacy labeled container with appropriate identifying information (name of child, medication dispensed, dosage prescribed, and the time it is to be given). If this is an over-the-counter product, the medication will be provided in the original container.*
- *I understand the medicine will be delivered to school personnel by a parent/guardian and that **students are not to transport medications.***
- *I hereby give permission for school staff (trained in medication administration) to administer the above-named medication to my child according to the healthcare provider's directions.*
- *I hereby release the LEA and all its agents and employees from any and all liability that may result from my child taking a prescribed medication or for injuries arising from a student's possession or self-administration.*

Parent/Guardian Signature: _____ Phone: _____Date: _____

School Nurse Signature: _____ Date: _____

DUPLIN COUNTY SCHOOLS

STUDENT HEALTH SERVICES

Medication Disposition

Rev: June 2026

Student: _____ DOB: __/__/__ School: _____

School Year: _____

Name of Medication: _____ **Dosage: _____** **Form(**tab,cap,syrup**): _____**

Medication Check-In:

Date	***Amount Received***	***Received from:*** *(signature)*	***Received by:*** *(signature)*

Medication Check-Out:

Date	***Amount Returned***	***Returned to:*** *(signature)*	***Returned by:*** *(signature)*

Disposal of Medication:

Date	***Amount Disposed***	***Method of Disposal***	***Disposed by:***	***Witnessed by:***