Harnett County Schools
Student Health

1/08

Request for Medication Administration at School

To be completed by physician:

Name of Student: _____ DOB: _____

Medication: _____ Dosage: _____

Time(s) medication is to be given: _____ To be given from:(date)_____ to _____ (or)____ Current School Year

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

Medical Condition(s) being treated: _____

Contraindications for Administration: _____

If an emergency situation occurs during the school day 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-ADMINISTRATION

☐ Student has demonstrated understanding of and the ability to carry and self-administer the medication prescribed above to include asthma medication, diabetes medication, or medication for anaphylactic reactions.
[Asthma medication: ☐ MDI (*Metered Dose inhaler) ☐ MDI with spacer*;
Allergic/Anaphylactic reaction medication: ☐ Epinephrine Auto-injector; Diabetes medication ☐ Insulin]

** Parent/ Guardian must provide an extra inhaler to be kept at school in case of an emergency and the student must have a "Student Agreement For Self-Carried Medication" form completed and reviewed by the school nurse or designee.*

A written statement, treatment plan and written emergency protocol developed by the student's health care provider must accompany the authorization form in accordance with requirements stated in G. S. 115C-375.2. Standard forms for most-common diagnosis may be obtained from the school secretary or school nurse. All medication for use at school must be delivered by parent/guardian in a container properly labeled by a pharmacist with identifying information, (name of child, medication dispensed, dosage prescribed, and the time it is to be given or taken).

_____ _____
Physician's Signature Date

Parent Permission

I hereby give my permission for my child (named above) to receive medication during school hours. A licensed physician has prescribed this medication; therefore, I hereby release the Harnett County School Board and their agents and employees for all liability that may result from my child taking the prescribed medication. I consent for the medical provider to disclose health or medical information regarding the above prescribed medication. This consent is good for the current school year unless revoked in writing.

_____ _____ _____
Parent/Guardian's Signature Daytime Telephone Number(s) Date

(School Use Only)

Approved by: _____ _____
Principal's Signature Date

Reviewed by: _____ _____
School Nurse's Signature Date