Johnston County Schools

(919)934-9810 PO Box 1336, Smithfield, NC 27577 (919)934-9858

Request for Medication Administration in School

To be completed by physician only:

Name of Student: _____ School: _____

Medication: _____ Dosage: _____

Time(s) medication is to be given: _____ am and/or _____ pm. Medication is to be given from (date) _____ to _____.

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

_____

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 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 Dos Inhaler) ☐MDI with spacer* ☐Epi-pen ☐Diabetes-insulin}

*Parent/guardian must provide an extra inhaler to be kept at school in case of emergency.

A written statement, treatment plan, and written emergency protocol developed by the student's health care provider must accompany this authorization form in accordance with requirements stated in G.S. 115C-375.2.

Student must have a self-medication treatment contact.

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 Signature Date

PARENT'S PERMISSION

I hereby give my permission for my child (named above) to receive medication during school hours. 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

FOR SCHOOL USE ONLY

Name and title of person to administer medication (unless self-administered) _____

Approved by: _____ _____

Principal's Signature Date

Reviewed by: _____ _____

School Nurse's Signature Date