TYRRELL COUNTY SCHOOLS
MEDICATION AUTHORIZATION FORM

Part A: To be completed by medical provider Date:_____

Name of Student:_____Date of Birth:_____

School:_____

Medication:_____Dosage:_____Route:_____

Time(s) medication is to be given: a.m.____p.m.____ To be given from date:_____to_____

Significant Information (side effects, toxic reactions, 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:_____Fax:_____
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. (___MDI (*Medicated Dose Inhaler) ___MDI with spacer *___Epinephrine auto-injector ___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 contract.

All prescription medication for use at school will be furnished by parent/guardian in a container properly labeled by a pharmacist and over-the-counter medicine must be in the original container. All medicines must have 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:_____

Physician's Printed Name:_____

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/Guardian Signature_____Date:_____

Telephone Number: Home_____Other_____

(School Use Only)

Approved/Signed by Principal/Designee_____Date:_____

Reviewed/Signed by School Nurse:_____Date:_____