Haywood County Schools/ Authorization for Medication Administration in School

Name of Student: _____ School: _____

Health Care Provider/Physician Name: _____

To be completed by Health Care Provider/Physician:

Medication: (each medication is to be listed on a separate form) _____

Dosage and Route: _____

Time(s) medication is to be given: a.m. _____ p.m. _____ PRN _____

To be given from: (date) _____ to/through: _____

Contraindications to administration: _____

EMERGENCY MEDICATIONS FOR SELF-ADMINISTRATION-

☐ Student has demonstrated ability and understands the use of and may carry and self-administer the following medications:

Asthma/allergic reaction: _____ MDI (Metered Dose Inhaler) _____ MDI with spacer

Allergic /Anaphylactic reaction: Epinephrine auto injector _____

Diabetic Medication: Insulin _____ Glucose _____ Glucagon _____

Parent/guardian must provide inhalers, epinephrine, diabetic supplies/medication to the school; new ones must be supplied when it expires. A spare is recommended to be kept in the office in case of an 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.

Date: _____ Provider's Signature _____

PARENT'S PERMISSION

I hereby give permission for my child _____ to receive medication during school hours. This medication has been prescribed by a licensed health care provider. I hereby release the Haywood County School Board and their agents /employees from all liability that may result from my child taking the prescribed medication. This consent is good for the school year unless revoked. I will furnish all prescription medication for use at school 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/taken) and replace the medication when it expires. I will furnish all over the counter medication in the original container. My child may carry emergency medications identified in the box above.

Parent/Guardian Signature: _____

Telephone Number: _____ Date: _____

Reviewed by School Nurse: _____ Date: _____

Adapted from NC School Health Manual/June 2016/ssc

MEDICATION ADMINISTRATION LOG

STUDENT NAME: _____ TEACHER: _____ GRADE: _____

SCHOOL: _____ SCHOOL YEAR: _____

MEDICATION: _____ ROUTE: By mouth Injected Inhaled Topical Rectum (CIRCLE ONE)

DOSE: _____ TIME TO GIVE: _____

(STRENGHT AND AMOUNT TO GIVE) (WITH IN + OR – 30 MINUTES)

****PLEASE USE THE FOLLOWING CODES TO DOCUMENT THE REASON MEDICATION WAS NOT GIVEN OR OMITTED****

ED = EARLY DISMISSAL DC = DISCONTINUED AT PARENTS REQUEST R = REFUSED AB = ABSENT FT = FIELD TRIP NMS = NO MEDICATION AT SCHOOL NS = NO SCHOOL

****REASON FOR GIVING MUST MATCH REASON LISTED ON PERMISSION FORM****

DATE	TIME	DOSE	REASON GIVEN OR NOT GIVEN	INITIALS	DATE	TIME	DOSE	REASON GIVEN OR NOT GIVEN	INITIALS

ADMINISTERED BY: _____ _____ _____

INITIALS / SIGNATURE INITIALS / SIGNATURE INITIALS / SIGNATURE