HAYWOOD COUNTY SCHOOLS

AUTHORIZATION FOR PRESCRIPTION MEDICATION AT SCHOOL

STUDENT'S NAME _____ **BIRTHDATE** _____

DATE _____ **SCHOOL** _____ **TEACHER** _____ **GRADE** _____

DOCTOR'S NAME _____ **DOCTOR'S PHONE NUMBER** _____

MEDICATION _____ **STRENGTH** _____
(EXAMPLE 25MG PER PILL)

DOSAGE _____
(AMOUNT TO BE GIVEN)

ROUTE OF ADMINISTRATION _____
(EXAMPLE: BY MOUTH, INJECTION, INHALED (INHALER), TOPICAL (APPLY TO SKIN), OR RECTAL)

TIME TO GIVE MEDICATION OR HOW OFTEN TO GIVE _____ AM OR PM
(EXAMPLE: 2 PM OR EVERY 4-6 HOURS AS NEEDED)

EFFECTS THIS MEDICATION HAS ON YOUR CHILD _____
(EXAMPLE: SLEEPY, SHAKY, OR NO PROBLEM AT ALL)

****** NO INJECTIONS WILL BE GIVEN EXCEPT IN EXTREME EMERGENCY (SUCH AS EPI-PEN OR GLUCAGON) ******

PRESCRIPTION MEDICATIONS CAN BE ACCEPTED IF:

1. **PHARMACY LABEL IS ATTACHED**
   ORIGINAL PHARMACY LABEL ATTACHED (INCLUDING STUDENTS NAME, DATE OF BIRTH, MEDICATION NAME, STRENGTH, DOSAGE, ROUTE, AND PRESCRIBING PHYSICIANS NAME.

OR

2. **PHYSICIAN COMPLETING INFORMATION ABOVE, HIS SIGNATURE, AND DATE OF ORDER.**
   ******Medication must be brought to school by the parents/ guardians in the original box/container with label Including child's name, date of birth, route, dose, and frequency ******

PHYSICIAN'S SIGNATURE _____
PRINT NAME _____

PARENT'S PERMISSION

I HEREBY GIVE MY PERMISSION FOR MY CHILD (NAMED ABOVE) TO RECEIVE MEDICATION DURING SCHOOL HOURS. I UNDERSTAND THE SCHOOL UNDERTAKES NO RESPONSIBILITY FOR THE ADMINISTRATION OF THE MEDICATION. THIS MEDICATION HAS BEEN PRESCRIBED BY A LICENSED PHYSICIAN. I HEREBY RELEASE THE HAYWOOD COUNTY BOARD OF EDUCATION AND THEIR AGENTS AND EMPLOYEES FROM ANY AND ALL LIABILITY THAT MAY RESULT FROM MY CHILD TAKING THE PRESCRIBED MEDICATION. I AGREE TO NOTIFY THE SCHOOL OF ANY CHANGES IN THE PRESCRIPTION AND COMPLETE A NEW PRESCRIPTION FORM.

PARENT/GUARDIAN SIGNATURE _____ **Contact Number** _____

REVIEWED BY: _____ **SCHOOL NURSE** **DATE:** _____

REVISED 7/2010 HCHD

MEDICATION ADMINISTRATION LOG

STUDENT NAME: _____ **TEACHER:** _____ **GRADE:** _____

SCHOOL: _____ SCHOOL YEAR: _____

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

DOSE: _____ TIME TO GIVE: _____

(STRENGTH AND AMOUNT TO GIVE) **(WITH IN + OR - 30 MINUTES)**

Reason for giving medication: _____

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

ED = EARLY DISMISSAL **DC** = DISCONTINUED AT PARENTS REQUEST/DR. REQUEST **R** = REFUSED **AB** = ABSENT **FT** = FIELD TRIP **NMS** = NO MEDICATION AT SCHOOL **NS** = NO SCHOOL
RX=PRESCRIPTION B=EMPTY BOTTLE SENDT HOME N=NOTE SENT HOME/LOW ON MEDS

******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

ev. HCHD 20.