Medication Authorization for Students

Student's Name: _____ **Birth Date:** _____

School Year: _____ **Grade:** _____

In order to keep this student in optimum health and to help maintain maximum school performance and sustain attendance, it is necessary that medication be given during school hours.

Name of Medication: _____

***Only one medication on each med auth form.**

Circle One: Tablet Capsule Liquid Inhaler Nebulizer* Patch Drops Injection* Rectal* Other: _____
*Please indicate physical condition for which specialized physical health care (nursing type) procedure is to be provided:

_____

Dosage (amount to be given) _____

Time/Frequency: _____A.M. _____ P.M. or As Needed every _____

Reason for Medication: _____

Side Effects (expected or predicable): _____

Termination Date: _____ (All medication orders expire at the end of the school year unless otherwise stated.)

Physician's Signature: _____ Date: _____

Physician's Name Printed: _____ Telephone #: _____

Parent Authorization: Please sign the authorization that applies to your child below.

Parent permission for medication to be administered by the school nurse/staff:

- 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.
- I will furnish all 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 or taken).

Parent/Guardian Signature: _____Phone: _____ Date: _____

OR

Parent Permission for medication to be SELF-ADMINISTERED by their child (K-5 consult with School Nurse):

- I agree to the Medication authorization as written by the above medical provider.
- I hereby request that my child be allowed to carry and self-administer the medication at school as prescribed by my child's licensed health care provider. I understand my child must carry this medication at all times in school or he/she will lose the right to carry it. I further understand that the school undertakes no responsibility for the administration of the medication. I hereby release the School Board, its agents and employees, from any and all liability that may result from my child taking this medication. My child is knowledgeable about this medication and how to self-administer it.
- I agree to ensure that the medication will have a pharmacy label with my child's name.

Parent/Guardian Signature: _____Phone: _____ Date: _____

Reviewed by School Nurse: _____ Date: _____

Student's Name: _____ **Grade:** _____

Important Information about Medication Administration in Schools

- When possible, medications should be taken before or after school.
- Written parent/guardian consent and an order from a licensed healthcare provider are required for administering prescription and over-the-counter medications at school. Contact the school nurse for help if relocating to Cabarrus County. Some medications may not be suitable for a school setting. Contact the school nurse if you have questions.
- No medication will be given at school until this authorization has been reviewed and signed off by the School Nurse.
- Medications are given by a nurse or school staff trained by the School Nurse.
- Each medication must be in the original labeled container from the pharmacy or healthcare provider's office. Some pharmacies will provide an extra container for school use.
- Medications kept in the school health office will be sent on school sponsored field trips.
- Medications stored in the school health office will not be available during non-school hours. It is the responsibility of the parents/guardians to assure that necessary emergency medications are available to students during non-school hours for before or after school clubs/programs.
- Information about this medication and the student's health may be shared with other school staff or agents of the school to help assure the student's safety and success at school.
- The school nurse may contact the healthcare provider who prescribed the medication and the pharmacy where the prescription was filled to discuss this medication.
- New authorization forms are required at the beginning of every school year, when the dose or directions change, and when a new medication is prescribed. Parents/guardians must supply the medications.
- When a student self-administers an OTC medication without school staff support, the drug must be sent in the original container with only 1or 2 doses with a written authorization signed by the parent and attached to the container. The authorization must also include the date, time and amount of medication to be self-administered by the student.

Student Contract for Self-Administered Medication

Student Responsibilities:

- I plan to keep my inhaler, equipment, Epi-pen or other medication with me at school rather than in the school nurse's office.
- I agree to use my inhaler, equipment, Epi-pen or other medication in a responsible manner, in accordance with my licensed health care provider's orders.
- I will notify the school health office or main office if I am having more difficulty than usual with my health condition.
- I will not allow any other person to use my inhaler, equipment, Epi-pen or other medication.
- I will carry the least amount of medication possible in its original container.

Student's Signature: _____ Date: _____

School Nurses Responsibilities:

- Emergency Action Plan complete and on file at school
- Demonstrates correct use/administration
- Recognizes proper and prescribed timing for medication
- Agrees to carry medication or keep in an established location
- Knows health condition well
- Keeps a second labeled container in the health room
- Will not share medication or equipment with others.

Comments:

School Nurse Signature: _____ Date: _____