Brunswick County Schools

PHYSICIAN'S AUTHORIZATION FOR MEDICATION AT SCHOOL

To be completed by Healthcare Provider

Name of Student: ______________________________ Birth Date: ____________ Teacher:________________

Medication: _____________________________ Dosage: _________________________ Route: _____________

Time(s) medication is to be given or how often ____

Significant Information (include side effects, toxic reactions, omission reactions):

____

Contraindications for Administration ____

This medication is to be kept in a locked area and will be provided and transported to and from school by parent or guardian in a container properly labeled by a pharmacist with identifying information (e.g., name of child, medication dispensed, dosage prescribed, route, and the time it is to be given).

COMPLETE IF PRESCRIBING MEDICATION FOR ASTHMA, ANAPHYLACTIC OR DIABETIC STUDENTS ONLY

Students may possess and self-administer asthma, anaphylactic, or diabetic medication during the school day and/or school activities. Circle **Yes** or **No**

Student has been instructed, states understanding, and demonstrates skills necessary to possess and self-administer medication at school. Circle **Yes** or **No**

For those students who self-administer medication, backup medication shall be kept at the school per G.S. 115c-375.2. This student has a written treatment plan.

STUDENT ACKNOWLEDGMENT OF SELF-ADMINISTERED MEDICATION

I understand and have demonstrated to the school nurse or nurse's designee the skill level necessary to self-administer medication. I agree not to share medication or supplies with anyone.

____________________________________ ____

Student's Signature Date School Nurse's Signature Date

If an emergency occurs during the school day or if the student becomes ill, school officials should call parents, my office or 911.

___________________________________ ______________________________ _______________

Healthcare Provider Signature & Physician's Stamp **Telephone/Fax Number** **Date**

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PARENT'S PERMISSION

I hereby give 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.

__________________________________ __________________________ ____________

Parent or Guardian Signature **Telephone Number** **Date**

Reviewed by ____

School Nurse's Signature Date

Brunswick County Schools
&
NC School Health Program Manual

Letter to Parent Regarding Administration of Medication in School

Dear Parent:

Our school has a written policy to assure the safe administration of medication to students during the school day. If your child must have medication of any type, including over-the-counter drugs given during school hours, you have the following choices:

1. You may come to school and give the medication to your child at the appropriate time(s).

2. You may obtain a "Physician's Authorization for Medication" form from the school nurse or school secretary. Take the form to your child's doctor and have him/her complete the form by listing the medication(s) needed, dosage, and number of times per day the medication is to be administered. This form must be completed by the physician for both prescription and over-the- counter drugs. The form must be signed by the doctor and by you, the parent or guardian. Prescription medicines must be brought to school in a pharmacy-labeled bottle which contains instructions on how and when the medication is to be given. Over-the-counter medication(s) must be received in the original container and will be administered according to the doctor's written instructions.

3. Parents or designated adult (not the student) must always bring medication to the main office for clearance.

4. You may discuss with your doctor an alternative schedule for administering medication (i.e., outside of school hours).

4. Self-medication: In accordance with G.S. 115C-375.2 and G.S. 115C-47, students requiring medication for asthma, anaphylactic reactions, or both, and diabetes may self-medicate with physician authorization, parent permission, and a student agreement for self-carried medication.

6. A new permission form is required each school year.

School personnel will not administer any medication to students unless they have received a medication form properly completed and signed by both doctor and parent/guardian, and the medication has been received in an appropriately labeled container. (Prescription or over-the-counter)

If you have questions about the policy, or other issues related to the administration in the schools, please contact the school nurse at the following number: _____________.

Thank you for your cooperation,

School Nurse ______________________________

Principal __________________________________