COLUMBUS COUNTY SCHOOLS
817 Washington St., Whiteville, NC 28472
(910) 642-5168

Request for Medication Administration in School

To be completed by physician or licensed primary care provider:

Name of Student:____DOB:_______________
School/Grade/Teacher____
Medication: ___________________________ (each medication is to be listed on a separate form)
Diagnosis: ______________________________ Dosage___________ Route: _______________
Time(s) daily medication is to be given: a.m._______________ p.m._______________
Time(s) to give PRN(as needed) medication: ____
To be given from: (date)_____________ to/through:__________________________________
Significant Information (include side effects, toxic reactions, reactions if omitted, take with/without food, etc.)____
____
Contraindications for Administration (reasons not to give):______________________________
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__________________________
print name phone number

b. Take child immediately to the emergency room at ____________________________

FOR SELF-ADMINSTRATION -

☐Student has demonstrated ability and understands the use of and may carry and self-administer asthma medication, diabetes medication, or medicine for anaphylactic reactions.
[Asthma/allergic reaction ☐MDI (*Metered Dose inhaler) ☐MDI with spacer *
☐Epinephrine ☐diabetes –insulin ☐ diabetes – glucose]
*Parent/guardian must provide an extra inhaler/epinephrine injector/source of glucose 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 ***The student also must have a self-medication agreement on file***.

Date_______________ Physician's Signature____

To be completed by parent:

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.
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 or Legal Guardian's Signature Telephone Number Date

(School Use Only)
Name and title of person to administer medication (unless self-administered)__________________________________

Approved by______________________________________ ____________________________
Principal's Signature Date
Reviewed by ______________________________________ ____________________________
School Nurse's Signature Date