HARNETT COUNTY SCHOOLS
Health Services

Request For Medication Administration at School

PHYSICIAN TO COMPLETE:

Name of Student: _____ DOB: _____
Medication: _____ Dosage: _____
Time(s) medication is to be given: _____a.m. _____ p.m._____
To be given from (start and stop dates): _____to _____OR (check) ____ Current School Year
Significant Information (include side effects, toxic reactions, omission reactions): _____
Medical Conditions being treated: _____ Contraindications for administration:_____
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 _____ Telephone _____
b. Take child immediately to the emergency room at _____

FOR SELF-ADMINISTRATION

☐ Student has demonstrated understanding of and the ability to carry and self-administer the asthma, diabetes, or medication for anaphylactic reactions prescribed above.

☐ Student has demonstrated understanding and the ability to carry and self administer the medication listed above.

Asthma medication - MDI *(Metered Dose inhaler)* MDI with spacer ** **Parent/ Guardian must provide an extra inhaler to be kept at school in case of an emergency.**

Diabetes Medication - Insulin **Allergic/Anaphylactic reaction medication -** Epinephrine Auto-injector

Student must have a "Student Agreement For Self-Carried Medication" form completed and reviewed by the school nurse or designee.

A written statement, treatment plan and written emergency protocol developed by the student's health care provider must accompany the administration form for students to self carry and administer rescue medication in accordance with requirements stated in G. S. 115C-375.2. Standard forms for most common diagnosis may be obtained from the school or our on-line sources.
All medication for use at school must be delivered by parent/guardian 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) or for OTC medications-in the manufacturer's labeled container.

_____ _____
Physician's Signature Date

Parent Permission
I hereby give my permission for my child (named above) to receive medication during school hours. A licensed physician has prescribed this medication; therefore, I hereby release the Harnett County School Board, their agents and employees for all liability that may result from my child taking the prescribed medication. I consent for the medical provider to disclose health or medical information regarding the above prescribed medication. This information will be shared with school staff as deemed necessary unless you state otherwise. I agree to inform school staff of any change in my child's health status that would warrant change in this action plan. This consent is good for the current school year unless revoked in writing.

_____ _____ _____
Parent/Guardian's Signature Daytime Telephone Number(s) Date

Approved by : _____
Principal's Signature Date

Reviewed by: _____
School Nurse's Signature Date