American Renaissance School

"A Downtown Community School"

Request for Medication Administration in School

To be completed by physician

Name of Student: _____
School: _____

Medication: (each medication is to be listed on a separate form)
_____

Dosage and Route: _____

Time(s) medication is to be given: a.m. _____ p.m. _____PRN: _____
To be given from: (date) _____ to/through: _____

Significant Information (include side effects, toxic reactions, reactions if omitted, etc.)
_____

Contraindications to 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_____
b. Telephone _____

   Take child immediately to the emergency room at _____

FOR SELF-ADMINISTRATION –
☐ **Student has demonstrated ability and understands the use of and may carry and self- administer asthma medication, diabetes medication, or medicine for anaphylactic reactions only.**

Asthma/allergic reaction __MDI (*Metered Dose inhaler) __MDI with spacer * Diabetes __ insulin __ glucose __Epinephrine

*Parent/guardian must provide an extra inhaler/epinephrine injector/source of glucose to be kept at school in case of emergency and that will be replaced when it expires.
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_____

(Over)

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) and replace the medication when it expires.

Parent or 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