CONSENT FOR MEDICATION ADMINISTRATION DURING SCHOOL HOURS

(This form is a medication form for over-the-counter and prescription medications)

All sections to be completed by physician

Name of Student _____ School _____

Medication _____ Dosage _____

_____ **(check if applies) Student needs to carry/use medication at school**

Time(s) medication is to be given: am____ pm____

Dates to be given (***Valid one school year***) ____ to ____

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

_____

_____

Contradictions for Administration: _____

If an emergency situation occurs during the school day or if the student becomes ill, school officials are to: (Check all that apply)

_____ 1. Contact me at my office _____
Physician Name and Telephone Number

_____ 2. Take child immediately to the emergency room at _____

_____ 3. Call 911

_____ 4. Other option _____

This medication will be furnished by the parent or guardian within a container properly labeled by a pharmacist with identifying information, (e.g. name of child, medication dispensed, dosage prescribed, and the time it is to be given)

_____ _____ _____
Physician Name (print) Physician Signature & DEA # Date

****

Parent's Permission

I hereby give my permission for my child named above to receive and/or carry/use medication during school hours. This medication has to be prescribed by a licensed physician. I hereby release the Vance County School Board and its agents and employees from all liability that may result from my child taking the prescribed medication. I also authorize my child's medical provider to release information to the school nurse that is deemed necessary for the administration of medications at school in accordance with the Health Insurance Portability and Accountability Act of 1996.

_____ _____ _____
Parent Signature Telephone Number Date

_____ _____
Emergency Contact Name Telephone Number

(School Use Only)

Name and title of person trained to administer medication _____

Approved by _____ _____
School Nurse Signature Date

5/05