

Neuse Charter School

Request for Medication Administration in School

To be completed by physician only:

Name of Student: _____ School: _____

Medication: _____ Dosage: _____

Time(s) medication is to be given: _____ am and/or _____ pm. Medication is to be given from (date) _____ to _____.

Side effects/reactions: _____

Contraindications for Administration: _____

If an emergency situation occurs during the school day or if the student becomes ill, school officials are to:

Take child immediately to the emergency room at _____

SELF-ADMINISTRATION

I have instructed this student in the proper way to use his/her medication. Student has demonstrated understanding of and ability to self-administer asthma medication, diabetes medication, or medicine for anaphylactic reactions. It is my professional opinion that he/she should be allowed to carry this medication and administer to himself/herself.

*Parent/guardian must provide extra medication to be kept in school office in case of emergency.

Print/Stamp physician name, address and phone number:

Physician's Signature

Date

All medication for use at school will be furnished by parent or guardian in 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 or taken).

Parent 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.

Parent/Guardian's Signature

Telephone Number

Date

Parent E-mail address

Principal's Signature

Date

School First Responder's Signature

Date