Johnston County Schools

(919)934-9810 PO Box 1336, Smithfield, NC 27577 (919)934-9858

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 Nurse's Signature ______________________________ Date ______________

Revised 4/09