Teacher_____Grade_____

Authorization for Medication Administration

Whenever possible, medication should be administered at home. If a medication is to be administered at school, an authorization form must be signed by a health care provider licensed to prescribe medications and by the parent/guardian. Prescription medication must be in the most current pharmacy labeled container. Over the counter medications must be provided in the original container and in limited quantities. Only one medication per form is permitted, and a new form must be completed each school year and anytime the dose or instructions change. Medications are not to be transported by students (unless approved by the school nurse to self-carry) and must be checked in by an adult.

Medication Order: Licensed Medical Provider Use Only

Student Name:_____DOB:_____School:_____

Medication:_____Dosage:_____Route:_____Frequency:_____

Purpose of Medication:_____School Year:_____

Possible Side Effects/Adverse Reactions:_____

Self Administration of Medication(s): Licensed Medical Provider Use Only

Asthma inhalers, epinephrine auto injectors, and diabetes medication(s) and supplies may be carried and self-administered according to North Carolina General Statures with a signature from the student's licensed medical provider.

☐_____ (Initials of Medical Provider) I agree that this student demonstrates the knowledge and skills necessary to self-medicate. (Limited to asthma inhalers, epinephrine auto injectors, and diabetes supplies and medications)

Licensed Medical Provider Signature and Verification

Provider Signature:_____Date:_____

Clinic Stamp	Parent/Guardian Signature and Release of Liability
	I request that my child (named above) receive this medication as instructed above. I understand it is my responsibility to provide the medication to the school in the appropriately labeled container. I give my permission for the school nurse to contact my child's medical provider regarding the medication and his/her medical condition if necessary. I hearby release the Caswell County Board of Education and its agents from any liability related to administration of this medication to my child. Parent/Guardian Signature:_____ Date:_____ Telephone:_____

Reviewed:_____(School Nurse) Date:_____

Approved:_____(Principal) Date:_____

Medication Check-In & Sign-Out Log

Date	Medication	Amt. Rec'd	Received by (signature)	Received from (signature)

Medication Disposal/Destruction Log (If not picked up)

Date	Medication	Amount	Signature of RN	Signature of RN

Teacher_____Grade_____

Student Name:_____DOB:_____

Self-Administration Section (Limited to asthma inhalers, epinephrine auto injectors, and diabetes supplies/medications)

Parent Section

I give my consent for my child to possess and self-administer medication at school. I agree that my child is knowledgeable of his/her treatment and is capable of self-administering the prescribed medication. I release the Caswell County Board of Education and their agents and employees from any liability whatsoever related to any condition that may result from my child self-administering the prescribed medication.

Parent Signature:_____Date:_____

Student Section

I am capable of taking this emergency medication as recommended, and I accept the responsibility. I agree to use this medication as prescribed and to notify my teacher/bus driver/coach or other supervising adult as outlined in my treatment plan. I understand that it is my responsibility to keep my medication accessible at all times including transportation to and from school and at school sponsored events. I understand that I am subject to the disciplinary action according to the Student Code of Conduct if I abuse this privilege.

Student Signature:_____Date:_____

Self-Carry Check Off

_____ Emergency Action Plan complete and on file at school
_____ Demonstrates correct use/administration
_____ Verbalizes proper and prescribed timing for medication
_____ Agrees to carry medication
_____ Can describe own health condition well
_____ Keeps a second labeled container in health office/main office
_____Will not share medication or equipment with others

School Nurse Section

The student has demonstrated proper use of the medication and recognizes the indications for its use.

_____
School Nurse Signature

_____
Date

Nurse Notes

Date	