Page 1 Completed by Physician
Reverse Must Be Completed by Parent and Student (in presence of nurse if self-administering)

Request for Medication Administration in School

To be completed by Health Care Practitioner

Name of Student: ___________________________________ Date of Birth: ______________________
School: ____
Medication: (each medication is to be listed on 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 (to include side effects, toxic reactions, reactions if dose is missed, etc.)
____
Contraindications to administration: ____
Diagnosis: ____

FOR SELF ADMINISTRATION-

Student has demonstrated ability and has been determined to be competent for self-administration. Student also understands the medication directions and may carry/self-administer asthma medication, diabetes medication, and/or medicine for anaphylactic reactions only.

ASTHMA/ALLERGEN REACTION: MDI (metered dose inhaler) ___ MDI with spacer*_____
Epinephrine___
DIABETES: Insulin____ Glucose______

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

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 the requirements stated in G.S. 115c-375.2.

This order remains in effect for the current academic year only and must be renewed each school year. The administration of this medication to the student during the school day is necessary to maintain and support the student's continued presence in school.

Health Care Practitioner's Signature ______________________________ Date: ________

OVER →

PARENT'S PERMISSION

I hereby give my permission for my child _______________________________________ to receive medication during school hours. This medication has been ordered and prescribed by a licensed health care practitioner. I hereby grant permission for the school nurse to communicate with the prescribing health care provider about the medication prescribed. 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 one year, and may be revoked at any time.

I will furnish all medications for use at school in a container properly labeled by a pharmacist with identifying information, (name of child, medication dispensed, dosage prescribed, the time/frequency it is to be given or taken, the route of administration, the number of doses in the container, and the expiration date of the medication). All over the counter medications will include the order for administration (first part of this authorization form signed by the doctor) with the identifying information, (name of child, medication dispensed, dosage prescribed according to label, and the time it is to be give or taken), with the medication in the original container.

I will replace this medication when it expires. I will remove this medication from the school the last day of school. I understand medication not picked up will be destroyed after the last day of school.

Parent or Guardian Signature: ____

Telephone number(s): ____

Emergency contact number in case you cannot be reached: ____________________________________

Student Competence Checklist with Nurse for Self-Administered Medication

- ☐ I have verbalized the name of my medication, informed the nurse of how it is prescribed, and demonstrated competency in using this medication.
- ☐ I will use this medication (and any accompanying equipment) only as directed by my health care practitioner.
- ☐ I will not share my medication with anyone. Sharing medication or using it other than prescribed will result in disciplinary action.
- ☐ I will notify a teacher or staff member if I am having difficulty or need to see the nurse.
- ☐ I will keep my medication with me at all times while in school—location____________________

______________________________	______________________________	________________
Signature of Student	**Signature of Nurse**	**Date**

MCS Revised 02/16
MCS Revised 05/18
MCS Revised 08/19
MCS Revised 04/21