Phone 704-717-7550

REQUEST FOR MEDICATION ADMINISTRATION

(each medication must be listed on a separate form and renewed annually)

Form Valid for the 20_______ to 20________ School Year

Student Name:____ **Date of Birth:**___________ **Current School Grade:**_________

Medication:____ **Dosage:**_______________ **Route:**_____________

Time(s) medication is to be given: A.M. ______________ **P.M.** _____________ **PRN:** _____________

Side effects, Interactions, Etc: ____

Prescribing Health Care Provider Signature:	**Date:**
Health Care Provider Name:	**Phone #:**

Parent/Guardian Agreement: I give my permission for my child (named above) to receive medication during school hours as well as during school related activities. I agree to send the medication in its original container. As the parent/guardian of this child, I assume the responsibility of any adverse reactions this medicine may cause for my child and I, hereby, release the Board of Directors, School Administration and employees from all liability. I give permission for the school to fax this medication form to my child's healthcare provider (if needed) for their signature. I give permission for my child's healthcare provider to fax this form back to the school. I understand the school cannot guarantee the confidentiality of the fax machine.

Parent/Guardian Signature:	**Date:**
Parent/Guardian Name:	**Phone #:**

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SELF-MEDICATION STUDENT AGREEMENT *(only applicable for 6th grade and above)*

- Non emergent medications are kept in the office.
- Emergent Medications that can be carried by student *(only if this form is completed and on file)*:
  - **Asthma/Allergic Reactions: ____MDI (Metered Dose inhaler) ____MDI with spacer**
  - **Diabetes: _____Insulin ____ Glucose**
  - **Anaphylaxis: ____Epinephrine**

Health Care Provider Agreement: I agree that this student is authorized to medicate himself/herself, has been instructed and has demonstrated the skill level necessary to use the prescribed medication/device. In order to keep this child in optimum health and to aid school performance it is necessary that this medication be self-administered during school hours. The student's parent/guardian has been informed and is in full agreement.

Healthcare Provider Signature:
(Signature also required at top of form)

Parent/Guardian Agreement: I agree that my child (named above) is knowledgeable of his/her treatment and is capable of self-administering this medication. I understand that the school and its employees are not liable for an injury arising from a student's possession and self-administration of medication. If applicable, I understand that I should provide the school with backup medication that shall be kept in the office so my child has immediate access to their medication in the event my child forgets or loses their supply. I understand that all non-emergent medications will be kept in the office and it is my child's responsibility to go to the office when the medications are due or needed.

Parent/Guardian Signature:
(Signature also required at top of form)

Self-Medicating Student Agreement: I agree and understand how to take my medicine as prescribed by my doctor. I will not share my medicine with anyone. I will keep my emergency medicine in a safe and secure place away from other students. My non emergent medications will be kept in the office and I will go to the office to take them at the scheduled time or as needed. I understand that if I do not follow the above rules, I may lose my privilege to give myself my own medicine while at school.

Student Signature:	**Date:**

To comply with requirements stated in G.S. 115C –375.2, the following must be developed/signed by the student's health care provider and accompany this form: • ***Emergency Action Plan*** *(for students needing an Epi-Pen, Asthma, or Seizure medication;)* • ***Diabetes Care Plan*** *(for students with diabetes).*

******Turn all forms into front office.******

Reviewed by School Nurse:	*Date:*