Lenoir County Public Schools
A Commitment to Excellence for All Children

Parent Request and Physician's Order for Medications
To Be Given During School Hours

To be completed by a licensed health care provider:

Name of Student: _____ **School:** _____

Medication: _____ **Dosage:** _____ **Route:** _____

Time(s) medication is to be given at school: a.m. _____ **p.m.** _____

To be given from (date) _____ **to (date)** _____

Significant Information: (Include side effects, toxic reactions, omission reactions)

_____

For asthma inhaler, Epi-pen, or insulin users:
May Self Medicate_____ **May Not Self Medicate**_____

This medication will be furnished by parent or guardian within a container properly labeled by a pharmacist with identifying information, (e.g. name of the child, medication dispensed, dosage prescribed, and the time it is to be given) for prescription drugs or in the original container for over-the-counter drugs.

_____ _____
Licensed Health Care Provider Signature **Date**
DEA#_____

PARENT'S PERMISSION

I hereby give my permission for my child to receive this medication at school. I understand that the school undertakes no responsibility for the administration of the medication. A licensed health care provider has prescribed this medication. I hereby release the School Board and their agents and employees from any and all liability that may result from my child taking the prescribed medication. If an emergency situation occurs during the school day or the student becomes ill, school officials are to:
a. Contact me _____ **at** _____.
b. Take child immediately to the emergency room.

_____ _____ _____
Signature of Parent/Guardian **Telephone Number** **Date**

School Use Only
Reviewed by:_____ _____
School Nurse's Signature **Date**

*****Must be signed by both Physician and Parent*****

Lenoir County Public Schools shall not discriminate on the basis of race, age, religion, color, national origin, gender, marital/pregnant status, or disability.