ONSLOW COUNTY SCHOOLS STUDENT HEALTH SERVICES
Permission for Prescribed Medication to Be Given During School Hours

TO BE COMPLETED BY PARENT/GUARDIAN:

Date: ____________________ **School:** ________________________ **Teacher/Grade:** ____________________

Name of Student: ____ **Date of Birth:** ____________________

I hereby give consent for the school staff to administer this medicine to my child according to the physician's following directions. The school nurse has my permission to contact the physician should there be any questions or concerns regarding the medication.

I understand that medicine will be delivered to school personnel by a parent/guardian and that **students are not to transport medications**.**

I understand that this prescribed medicine will be in the **original pharmacy labeled container** with identifying information (e.g., name of child, medication name, dosage prescribed, and time of administration)

If this is an **over the counter medication,** the medication must be in the original, labeled container.

I hereby release the School Board and their agents and employees from any and all liability that may result from my child taking this prescribed medication and from any and all liability that may result from my child's self-medication.

Parent/Guardian(Print)______________________________ Signature______________________________________

Date______________________ Home# ___________________ Cell# __________________ Work# ____________

TO BE COMPLETED BY PRESCRIBING PHYSICIAN:

To help this student maintain school performance, it is necessary that the medication below be given during school hours.

Medication _____________________Strength ______________ Dosage _______________ Route: _____________

Time(s) medication to be given at school: a.m._____________ p.m._____________

As Needed/PRN _________________________ *Circumstance:____

*(If medication is ordered as needed, please indicate specific circumstances when medication should be given. Non-medical personnel may be administering the medication.)

Beginning date: ____________________________ Ending date: _______________________________________

Reason for medication: _____________________ Possible side effects: _______________________________

Known medication allergies __________________ Contraindications for Administration:_________________

EMERGENCY MEDICATIONS:

For ****emergency** medications, student **may/may not (circle one)** self-medicate.

****If this is an emergency medicine, I certify that the student has been instructed by me in its proper use and needs to carry it at all times**. Yes ________No ________ N/A ________

***For students with asthma*:** ** The student has an Asthma Action Plan. Yes ____ No ____

**The student uses/has a Peak Flow Meter. Yes ____ No ____

Physician's Name (Stamp)_______________________________________ Phone# ________________________

Physician's Signature____ Date____________________________

THIS FORM MUST BE RENEWED AT THE BEGINNING OF EACH SCHOOL YEAR AND WHENEVER THERE IS ANY CHANGE IN THE MEDICATION.

Nurse Signature ___________________________________ **Date**_______________________