Form A

PAMLICO COUNTY SCHOOLS

AUTHORIZATION OF MEDICATION FORM

TO BE COMPLETED BY PHYSICIAN/MEDICAL PROVIDER

Date: _____ Date of Birth: _____

Name of Student: _____

School: _____

In order to keep this student in optimum health and to help maintain school performance, it is necessary that medication be given during school hours.

Medication: _____ Dosage/mg _____ Route _____

Significant information: _____

Time(s) medication is to be given at SCHOOL: _____

* Providers, please note that "lunch time" can vary from 10:30 AM to 1:30 PM.

For asthma inhaler, insulin users or epi-pens

☐ May self-medicate (student has demonstrated proficient use of medication).

☐ May not self-medicate.

If medication is ordered as needed, please indicate specific circumstances when medication should be given (School staff, not licensed medicate or nursing personnel, will be administering medication):

_____

Medical Provider's Signature

_____

Telephone number

TO BE COMPLETED BY PARENT

I hereby give permission for my child, _____, to receive medication during school hours. This medication has been prescribed by a licensed physician. I hereby release the School Board and their agents and employees from any and all liability that may result from my child taking the medication.

_____

Signature of Parent/Guardian

_____/_____

Telephone number / Date