PITT COUNTY SCHOOLS
AUTHORIZATION FOR MEDICATION

TO BE COMPLETED BY PHYSICIAN/MEDICAL PROVIDER Date:_____

Name of Student_____

DOB:_____ School:_____

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

Medication_____Dosage/mg_____Route_____

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**

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

_____

For K-12 students authorized to carry and administer rescue medications such as asthma inhalers, epi-pens or insulin or high school students authorized to carry and administer medication, with the exception of Class 2 controlled substances such as Ritalin, Oxycontin, Percocet, Adderol, Concerta, please check the appropriate box.

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

☐ May not self-medicate.

_____ _____
Medical Provider's Signature Telephone Number

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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 Pitt County Board of Education 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

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TO BE COMPLETED BY STUDENT AUTHORIZED TO SELF-MEDICATE

I understand that it is a privilege for students to be allowed to self-medicate during school hours. Abuse of this privilege shall result in its revocation.

_____ _____
Signature of Student Date