Cape Fear Center for Inquiry

Physician's Authorization for Medication at School

To be completed by Healthcare Provider

Name of student _____ DOB: _____

Medication _____ Dosage _____ Route _____

Time(s) medication is to be given or how often _____

Significant information (include side effects, toxic reactions, omission reactions) _____

_____

_____

Contraindications for Administration _____

This medication is to be kept in a locked area and will be provided and transported to and from school by parent or guardian in a container properly labeled by a pharmacist with identifying information (e.g., name of child, medication dispensed, dosage prescribed, route, and the time it is to be given.)

COMPLETE IF PRESCRIBING MEDICATION FOR ASTHMA, ANAPHYLACTIC OR DIABETIC STUDENTS

Student may possess and self-administer asthma, anaphylactic, or diabetic medication during the school day and/or school activities. Circle **Yes** or **No**

Student has been instructed, states understanding, and demonstrates skills necessary to possess and self-administer medication at school. Circle **Yes** or **No**

Student has a written treatment plan. Circle **Yes** or **No**
(If Yes, please attach a copy of the treatment plan to this form)

For those students who self-administer medication, backup medication must be kept at the school per G.S. 115c-375.2.

If an emergency occurs during the school day or if the student becomes ill, school officials should call parents, my office or 911.

_____

Healthcare Provider Signature Telephone number Date

Parent's Permission

I hereby give permission for my child (named above) to receive medication during school hours. This medication has been prescribed by a licensed physician. I hereby release the Board of Cape Fear Center for Inquiry and their agents and employees from all liability that may result from my child taking the prescribed medication.

_____

Parent or Guardian's Signature Telephone number Date

Student Acknowledgement of Self-Administered Medication

I understand and have demonstrated to the appropriate staff the skill level necessary to self-administer medication. I agree not to share medication or supplies with anyone.

Student's signature _____ Date _____

Reviewed by _____ Date _____