

**Cape Fear Center for Inquiry
Physician's Authorization for Medication at School**

To be completed by Healthcare Provider

Name of student: _____ School Year: _____
Medication: _____ Dosage: _____ Route: _____
Time(s) medication is to be given **at school**: _____
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/guardian in a container properly labeled by a pharmacist with identifying information (e/g., name of child, medication dispensed, dosage prescribed, route and time to be given.) Over-the-counter medications must be in the original container.

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, back up medication must be kept at the school.

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

Healthcare Provider's 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 healthcare provider. 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'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 signature: _____ Date: _____
Reviewed by: _____ Date: _____

