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.

COMPETE 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:_____