



# Johnston County Schools

(919)934-9810 PO Box 1336, Smithfield, NC 27577 (919)934-9858

4520-E(2)

## Request for Medication Administration in School

To be completed by physician

Name of Student: \_\_\_\_\_ School: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Time(s) medication is to be given: a.m. \_\_\_\_\_ p.m. \_\_\_\_\_ To be given from: (date) \_\_\_\_\_ to \_\_\_\_\_

Significant Information (include side effects, toxic reactions, omission reactions): \_\_\_\_\_

Contraindications for Administration: \_\_\_\_\_

If an emergency situation occurs during the school day or if the student becomes ill, school officials are to:

a. Contact me at my office \_\_\_\_\_ Telephone \_\_\_\_\_

b. Take child immediately to the emergency room at \_\_\_\_\_

### FOR SELF-ADMINISTRATION -

\_\_Student has demonstrated understanding of and ability to self-administer asthma medication, diabetes medication, or medicine for anaphylactic reactions and may carry and self-administer as prescribed.

[Asthma/allergic reaction \_\_MDI(\*Medicated Dose inhaler) \_\_MDI with spacer \* \_\_Epi-pen \_\_diabetes –insulin]

\*Parent/guardian must provide an extra inhaler to be kept at school in case of emergency

A written statement, treatment plan and written emergency protocol developed by the student's health care provider must accompany this authorization form in accordance with requirements stated in G.S. 115C –375.2

Student must have a self-medication treatment contract.

All medication for use at school will be furnished by parent or guardian in a container properly labeled by a pharmacist with identifying information, (e.g., name of child, medication dispensed, dosage prescribed, and the time it is to be given or taken).

\_\_\_\_\_  
Physician's Signature Date \_\_\_\_\_

### PARENT'S PERMISSION

I hereby give my 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 School Board and their agents and employees from all liability that may result from my child taking the prescribed medication. This consent is good for the school year, unless revoked.

\_\_\_\_\_  
Parent or Guardian's Signature Telephone Number Date

(School Use Only)

Name and title of person to administer medication (unless self-administered) \_\_\_\_\_

Approved by \_\_\_\_\_  
Principal's Signature Date

Reviewed by \_\_\_\_\_  
School Nurse's Signature Date