AUTHORIZATION FORM FOR ADMINISTERING DRUGS OR MEDICATION AT SCHOOL

Employees and agents of Dare County Schools are authorized to administer medications only when the following conditions have been met:

1. *The student's parents or legal custodian has made a written request that school personnel administer the medication to the student and has given explicit written instructions describing the manner in which the medication is to be administered;*
2. *A physician has prescribed the medication for use by the student (for over-the-counter medications as well has medications available only by a physician's prescription);*
3. *A physician has certified that administration of the medication to the student during the school day is necessary (for over-the counter medications as well as medications available only by a physicians prescription);*
4. *The employee or agent administers the medication pursuant to the written instructions provided by the student's parent or legal custodian.*

Student_____DOB_____School_____Grade _____

Parent/Guardian_____Home Phone_____Work Phone_____

To be completed by Parent/Guardian:

I hereby give permission for _____ to receive_____
(Student's Name) **(Name of medication and dose)**
during school hours. Generic equivalents may be substituted. Prescription medications must be sent in the original container(s) with the student's identifying information and specific written directions as to conditions prescribed for, dosage, and time of administration.

Please list specific instructions (condition prescribed for, time of administration, & side effects):

I hereby give permission to authorized school personnel to administer the medications listed above during school hours pursuant to written directions. I hereby release the Dare County School Board, their agents and employees from all liability that may result from my child taking the medication. My signature indicates I have read and understand Policy 6125 Administering Medicines to Students.

If an emergency situation occurs during the school day, school personnel are to:

_____ _____
Parent/Guardian Signature Date

To be completed by Physician/Health Care Provider for Prescription and Over-the-Counter meds:

Medication_____Dosage_____Time_____

Medication_____Dosage_____Time_____

Contraindications for administration_____

For students with asthma, diabetes and/or those subject to anaphylactic reactions, the following permission is given for inhalers, insulin or epinephrine auto-injectors:

( ) _____has been instructed, has demonstrated and understands the proper use of his/her ***inhaler, insulin or epinephrine auto-injector*** & he/she should be allowed to carry it with him/her.
( ) _____should not carry his/her ***inhaler, insulin or epinephrine auto-injector*** with him/her.

_____ _____
Physician/Provider Signature Date

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