

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 as 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 physician's 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 Ibuprofen/Tylenol
 (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 Ibuprofen Dosage 200 mg tabs Time 1-2 tabs q6hr prn
 Medication Acetaminophen Dosage 500 mg tabs Time 1-2 tabs q4hr prn-pain
 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 _____