

Anderson Creek Academy Enrichment

Rev'd 8/2016

Student Health

Request For Medication Administration at School

PHYSICIAN TO COMPLETE:

Name of Student: _____ DOB: _____

Medication: _____ Dosage: _____

Time(s) medication is to be given: _____ a.m. _____ p.m. _____

To be given from (start and stop dates): _____ to _____ OR (check) _____ Current School Year

Significant Information (include side effects, toxic reactions, and omission reactions): _____

Medical Conditions being treated: _____ 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 _____

A written statement, treatment plan and written emergency protocol developed by the student's health care provider must accompany the authorization form for students to self carry and administer rescue medication in accordance with requirements stated in G. S. 115C-375.2. Standard forms for most common diagnosis may be obtained from the school secretary or school nurse.

All medication for use at school must be delivered by parent/guardian in a container properly labeled by a pharmacist with identifying information, (name of child, medication dispensed, dosage prescribed, and the time it is to be given or taken) or for OTC medications, in the manufacturer's labeled container.

Physician's Signature

Date

Parent Permission

I hereby give my permission for my child (named above) to receive medication during school hours. A licensed physician has prescribed this medication; therefore, I hereby release the Anderson Creek Academy Board, their agents and employees for all liability that may result from my child taking the prescribed medication. I consent for the medical provider to disclose health or medical information regarding the above prescribed medication. This information will be shared with school staff as deemed necessary unless you state otherwise. I agree to inform school staff of any change in my child's health status that would warrant change in this action plan. This consent is good for the current school year unless revoked in writing.

Parent/Guardian's Signature

Daytime Telephone Number(s)

Date

Approved by : _____

Principal's Signature

Date

Reviewed by: _____

School Nurse's Signature

Date