Brunswick County Schools
PHYSICIAN'S AUTHORIZATION FOR MEDICATION AT SCHOOL
To be completed by Healthcare Provider

Name of Student: _____ School: _____ Birth Date: _____

Medication: _____ Dosage: _____ Route: _____

Time(s) medication is to be given or how often _____

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 or guardian in a container properly labeled by a pharmacist with identifying information (e.g., name of child, medication dispensed, dosage prescribed, route, and the time it is to be given.)

COMPLETE IF PRESCRIBING MEDICATION FOR ASTHMA, ANAPHYLACTIC OR DIABETIC STUDENTS ONLY

Students 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**

For those students who self-administer medication, backup medication shall be kept at the school per G.S. 115c-375.2. This student has a written treatment plan.

If an emergency occurs during the school day or if the student becomes ill, school officials should call parents, my office or 911.

_____	_____	_____
Healthcare Provider Signature & Physician's Stamp	**Telephone/Fax 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 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.

_____	_____	_____
Parent or Guardian Signature	**Telephone Number**	**Date**

STUDENT ACKNOWLEDGMENT OF SELF-ADMINISTERED MEDICATION

I understand and have demonstrated to the school nurse or nurse's designee the skill level necessary to self-administer medication. I agree not to share medication or supplies with anyone.

_____
Student's Signature Date

Reviewed by _____
School Nurse's Signature Date