

CARTERET COUNTY SCHOOLS
PHYSICIAN'S AUTHORIZATION FOR MEDICATION
GIVEN DURING SCHOOL HOURS

To be completed by physician

STUDENT _____ SCHOOL _____

MEDICATION _____ DOSAGE _____

TIME (s) medication is to be given: am _____ pm _____

To be given from (date) _____ to _____

Significant Information: (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 _____ Tel. Number _____
b. Take child immediately to the emergency room at _____
c. Other option _____

_____ Date _____

DEA # _____

This medication will be furnished by PARENT OR GUARDIAN within a container properly labeled by a PHARMACIST with the identifying information, (e.g., name of child, medication dispensed, dosage prescribed, and the time it is to be given. (No injection will be given except in extreme emergency, such as allergy to wasp or bee sting.)

The above written order will not be changed without a written request provided by the Physician.

PARENT'S PERMISSION

I hereby give my permission for my child (name above) to receive medication during school hours. I understand that the school undertakes no responsibility for the administration of the medication. This medication has been prescribed by a licensed physician. I hereby release the School Board and their agents and employees from any and all liability that may result from my child taking the prescribed medication.

Signature of parent or Guardian _____

Telephone _____ Date _____

(school use only)

Approval by Principal _____ Date _____

Reviewed by School Nurse _____ Date _____