THE EPIPHANY SCHOOL

2201 Henderson Ave.
New Bern, NC 28560
252-638-0122

Prescription Medication Form 2009-2010

To be completed by a Physician/NP/PA:

Name of Student ____

Medication ____

Instructions:

Dosage_________________________________Time given: _____________________________________

Indications (for prn drugs) ____

____

To be given: from (date) _______________ to _______________ or entire school year________________

Significant information (include side effects, toxic reactions, omission reactions) ___________________________

____

Contraindications for administration ____

____

Physician/NP/PA contact information:

Print Name ____________________________ Telephone____________________________________

Prescription medication will be furnished by parent in properly labeled container by a pharmacist with identifying information (name of child, medication dispensed, dosage prescribed, and the time it is to be given).

Physician/NP/PA signature____ Date_____________________________

FOR SELF ADMINISTRATION: Student has demonstrated understanding of and ability to self-administer asthma, diabetes, allergy medication as prescribed and may carry:

- □ MDI/MDI with Spacer (medicated dose inhaler, provided by parent)
- □ Epi-pen
- □ Insulin

Physician/NP/PA signature___________________________________ Date_________________________

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Parent's Permission:

I hereby give my permission for my child (named above) to receive medication during school hours. This medication has been prescribed by a licensed Physician/NP/PA. I hereby release The Epiphany School and their agents and employees from all liability that may result from my child taking the prescribed medication

Parent's signature ______________________________ Date_____________ Phone #________________

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Over The Counter Medication Form 2008-2009
(include ointments/creams)

To be completed by Parent/Guardian: Medication Allergies: _______________

Name of student ____

To be given: from (dates) ________________________to ________________ or entire school year___________

Medication Name	Dose	Time to be given	Indications for use	Contraindications for use
Acetaminophen				
Ibuprofen				
Aleve				
Pamprin				
Benadryl (Diphenhydramine)				
Neosprin/Bacitracin ointment				
Hydrocortisone cream				
Benadryl cream				
Other:				

Physician/NP/PA signature ____Date____________

Parent's Permission:
I hereby give my permission for my child (named above) to receive this over the counter medication during school hours. I hereby release The Epiphany School and their agents and employees from all liability that may result from my child taking this medication.

Parent's signature ___________________________ Date ___________ Phone# _______________