

**ONslow COUNTY SCHOOLS STUDENT HEALTH SERVICES**  
**Permission for Prescribed Medication to Be Given During School Hours**

**TO BE COMPLETED BY PARENT/GUARDIAN:**

Date: \_\_\_\_\_ School: \_\_\_\_\_ Teacher/Grade: \_\_\_\_\_

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I hereby give consent for the school staff to administer this medicine to my child according to the physician's following directions. The school nurse has my permission to contact the physician should there be any questions or concerns regarding the medication.

I understand that medicine will be delivered to school personnel by a parent/guardian and that **students are not to transport medications.**\*\*

I understand that this prescribed medicine will be in the **original pharmacy labeled container** with identifying information (e.g., name of child, medication name, dosage prescribed, and time of administration)

If this is an **over the counter medication**, the medication must be in original, labeled container.

I hereby release the School Board and their agents and employees from any and all liability that may result from my child taking this prescribed medication and from any and all liability that may result from my child's self-medication.

Parent/Guardian (Print) \_\_\_\_\_ Signature \_\_\_\_\_

Date \_\_\_\_\_ Home # \_\_\_\_\_ Cell# \_\_\_\_\_ Work# \_\_\_\_\_

**TO BE COMPLETED BY PRESCRIBING PHYSICIAN:**

To help this student maintain school performance, it is necessary that the medication below be given during school hours.

Medication \_\_\_\_\_ Strength \_\_\_\_\_ Dosage \_\_\_\_\_ Route: \_\_\_\_\_

Time(s) medication to be given at school: a.m. \_\_\_\_\_ p.m. \_\_\_\_\_

As Needed/PRN \_\_\_\_\_ \*Circumstance: \_\_\_\_\_

\* (If medication is ordered as needed, please indicate specific circumstances when medication should be given. Non-medical personnel may be administering the medication.)

Beginning date: \_\_\_\_\_ Ending date: \_\_\_\_\_

Reason for medication: \_\_\_\_\_ Possible side effects: \_\_\_\_\_

Known medication allergies \_\_\_\_\_ Contraindications for Administration: \_\_\_\_\_

**EMERGENCY MEDICATIONS:**

For **\*\*emergency** medications, student **may/may not (circle one)** self-medicate.

**\*\*If this is an emergency medicine, I certify that the student has been instructed by me in its proper use and needs to carry it all times.** Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_

**For students with asthma:** \*\*The student has an Asthma Action Plan. Yes \_\_\_\_\_ No \_\_\_\_\_

\*\*The student uses/has a Peak Flow Meter. Yes \_\_\_\_\_ No \_\_\_\_\_

Physician's Name (Stamp) \_\_\_\_\_ Phone# \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

**THIS FORM MUST BE RENEWED AT THE BEGINNING OF EACH SCHOOL YEAR AND  
WHENEVER THERE IS ANY CHANGE IN THE MEDICATION.**

Nurse Signature \_\_\_\_\_ Date \_\_\_\_\_