

PAMLICO COUNTY SCHOOLS

REQUEST FOR MEDICATION TO BE GIVEN DURING SCHOOL HOURS

To be Completed by Physician

Name of Student: _____ School: _____

Medication: _____ Dosage: _____

(No injection will be given except in extreme emergency, such as allergy to wasp or bee sting.)

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

To be given from (date) _____ to _____

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

Contraindications for Administration: _____

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

Physician's Signature

Date: _____
DEA # _____

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. 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

Name and title of person to administer medication: _____

Approved by: _____
Principal's Signature _____ Date _____