Rowan-Salisbury School System

PHYSICIAN AUTHORIZATION FORM FOR PRESCRIPTION AND NON-PRESCRIPTION MEDICATION

Whenever possible medication should be administered at home. If a medication is to be administered by school personnel, a Physician's Authorization Form must be completed and signed by the prescribing physician and the parent. Prescription medication must be in the most current pharmacy labeled container. Over-the-counter medication must be provided in the original container with possible side effects listed. A new form must be completed each school year and anytime the dose or instructions change. Medication cannot be returned home with a student.

Student Name: _____ Date of birth: _____

School: _____ Teacher/Grade: _____

Medication: _____
(one medication per form)

Dose: _____ Relationship to meals: Before ☐ After ☐ N/A ☐

Type of Medication (circle): tablet/capsule inhalation liquid ointment injection other: _____

Directions for use of medication _____

_____

Time(s) medication is to be given at school: _____

Date medication is to start: _____ Date medication is to end: _____

Possible side effects (expected or predictable) _____

Time medication is administered at home: _____

SELF ADMINISTRATION OF MEDICATIONS (FOR PHYSCIAN'S USE, ONLY)

Asthma inhalers, epi-pens and diabetic supplies may be carried & self-administered according to North Carolina law with a physician's signature.

☐ _____**(physician's initials) I agree this student demonstrates the knowledge & skill necessary to self-medicate (limited to asthma inhalers, epi-pens and diabetic supplies)**

To maintain this student's optimum health and to maximize educational performance and attendance, it is necessary that this medication be given during school hours according to the above instructions.

_____
Physician's Signature

_____ _____
Telephone Number Date

Clinic Stamp

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I request that my child (named above) receive this medication as instructed above. I understand it is my responsibility to furnish this medication in the appropriate container to school. I give permission for the school nurse to contact my child's physician regarding their medication or health condition if necessary. I understand if any remaining medication is not picked up by the last day of school, it will be disposed of.

_____ _____ _____
Date Parent Signature Telephone Number

Parent: see back of form, please

(Revised 2/8/12)

FOR PARENT REVIEW

In order to protect your child's health:

- Your consent and written authorization from a licensed healthcare provider are required when it is necessary for your child to receive either prescription or nonprescription medication in the Rowan Salisbury School System.
- No medication will be given to your child until this authorization form has been received.
- A separate form is required for each medication.
- New authorization forms are required each school year, whenever the dose or directions change, or if a new medication is prescribed.
- It is your responsibility to furnish all medication to be given at school.
- Each prescription medication must be in the appropriately labeled pharmacy container. Most pharmacies will provide a second container for school if asked.
- Non-prescription medication must be in the original manufacturer's container with recommendations and side effects listed.

SELF MEDICATION SECTION

LIMITED TO APPROVED MEDICATION UNDER THE ROWAN SALISBURY SCHOOL MEDICATION POLICY

Parent Section

I give consent for my child to possess & self- administer this medication at school. I understand that my child and I assume responsibility for the proper use and safekeeping of this medicine. I absolve the school board, its agents and employees from any and all liability whatsoever that may result from my child possessing or taking this medicine at school.

Parent/Guardian Signature: _____

Date: _____ Daytime telephone number: _____

Student Section

I am capable of taking this medicine as recommended and accept this responsibility. I will keep it secure at all times and will not share it with others. I understand that I will be subject to discipline under the Student Code of Conduct if I abuse the privilege of being allowed to carry and self-medicate while at school or during school sponsored activities.

Student Signature: _____ Date: _____

School Nurse Section

I have reviewed this request & agree that this student has demonstrated he/she understands when & how to self- administer this medication.

School nurse or designee signature: _____ Date: _____

In compliance with federal law, the Rowan-Salisbury School System administers all education programs, employment activities, and admissions without discrimination because of race, religion, national or ethnic origin, color, age, military service, disability, or gender, except where exemption is appropriate and allowed by law.