Form A

PAMLICO COUNTY SCHOOLS

AUTHORIZATION OF MEDICATION FORM

TO BE COMPLETED BY PHYSICIAN/MEDICAL PROVIDER

Date: ______________________________ Date of Birth: ________________________

Name of Student: ____

School: ____

In order to keep this student in optimum health and to help maintain school performance, it is necessary that medication be given during school hours.

Medication: ____________________________ Dosage/mg ________________ Route __________

Significant information: ____

Time(s) medication is to be given at SCHOOL: ____

* Providers please note that "lunch time" can vary from 10:30 AM to 1:30 PM.

For asthma inhaler, insulin or Epi-pens users

- ☐ May self-medicate (student has demonstrated proficient use of medication).
- ☐ May not self-medicate.

If medication is ordered as needed, please indicate specific circumstances when medication should be given (School staff, not licensed medical or nursing personnel, will be administering medication):

____
Medical Provider's Signature

__________________________________ ____
Print Medical Provider's Name Telephone number

TO BE COMPLETED BY PARENT

I hereby give permission for my child, ______________________________, 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 medication.

____
Signature of Parent/Guardian

______________________/____________________
Telephone number / Date