

Yadkin County Schools— MEDICATION AUTHORIZATION FORM

SCHOOL: _____ HOMEROOM: _____ GRADE: _____ SCHOOL YEAR: _____

Dear Parent/Guardian:

We attempt to discourage administration of medication in the schools. However, if your physician decides it is necessary for your child to receive a medication during the school day, we must have authorization and specific instructions from your child's physician. Please take this medication form to your physician and have the instructions recorded regarding the administration of your child's medication. Per Yadkin County Schools Medication Policy, this includes prescription and over-the-counter medications.

PHYSICIAN'S INSTRUCTIONS FOR GIVING MEDICATION IN SCHOOL

Name _____ Birth Date _____

Medication (Include Trade Name) _____ Dosage _____

Medication to be given (Circle) Tablet Ointment Capsule Inhalation Liquid Other _____

Relationship to meals (Circle) Before After Does not matter _____

How often or at what time? _____ Emergency Use _____

Side effects _____

Contraindications for administration _____

Student's allergies _____

Physician's Signature

Date

Address

Telephone Number

Parental Permission

I give permission for the exchange of information (verbal, written, or faxed) between the above named health care provider and Yadkin County Schools' School Nurse, as needed. I understand that this information will remain confidential. I request and give permission for the school to administer the above medication prescribed by my child's physician to be given during the school hours. I hereby release the Yadkin County School Board and their agents and employees from any and all liability that may result from the administration of the above medication. I agree to bring/send the medication in a properly labeled container from the pharmacy.

Parent/Guardian Signature _____ **Date** _____ **Phone Number** _____

Self Administration Only- PHYSICIAN, PLEASE COMPLETE AND SIGN

The above named student has been diagnosed with asthma, anaphylaxis or diabetes and has demonstrated proper technique and understands the use of **MDI (*Metered Dose Inhaler), MDI with Spacer, EpiPen, or Insulin/Glucagon.**

This student may carry and self-administer this medication for asthma, allergic reaction, or diabetes. ***The parent/guardian should provide an extra Inhaler/Diabetes medication to be kept at school in case of an emergency.**

Physician's Signature _____ **Date** _____

I agree and feel competent to take my own medication as prescribed. I will not at any time, share my medication with another student and I will keep it secure from other students.

Student's Signature _____ **Date** _____