Bradford Prep Request for Medication Administration in School

To be completed by physician

Name of Student:_____
School:_____
Medication: (each medication is to be listed on a separate form)_____
Dosage and Route: _____
Time(s) medication is to be given: a.m._____ p.m._____ PRN: _____
To be given from: (date)_____ to/through:_____
Significant Information (include side effects, toxic reactions, reactions if omitted, etc.)
_____
_____
Contraindications for Administration: _____

If an emergency situation occurs during the school day or if the student becomes ill, school officials are to:

a. Contact me at my office_____
   Telephone_____
b. Take child immediately to the emergency room at _____

FOR SELF-ADMINSTRATION -

☐ Student has demonstrated ability and understands the use of and may carry and self-administer asthma medication, diabetes medication, or medicine for anaphylactic reactions.

[Asthma/allergic reaction: ☐ MDI (*Metered Dose inhaler) ☐ MDI with spacer *
☐ Epinephrine ☐ diabetes –insulin ☐ diabetes – glucose]
*Parent/guardian must provide an extra inhaler/epinephrine injector/source of glucose to be kept at school in case of emergency

A written statement, treatment plan and written emergency protocol developed by the student's health care provider must accompany this authorization form in accordance with requirements stated in G.S. 115C –375.2 The student also must have a self-medication agreement on file.

Date_____ Physician's Signature_____

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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 all liability that may result from my child taking the prescribed medication. This consent is good for the school year, unless revoked.
I will furnish all medication for use at school in a container properly labeled by a pharmacist with identifying information, (name of child, medication dispensed, dosage prescribed, and the time it is to be given or taken).

_____	_____	_____
Parent or Guardian's Signature	Telephone Number	Date

(School Use Only)

Name and title of person to administer medication (unless self-administered)_____

Approved by: _____ _____
Principal's Signature **Date**

Reviewed by: _____ _____
School Nurse's Signature **Date**