Longleaf School of the Arts
322 Chapanoke road ▪ Raleigh, NC 27603 ▪ (919) 896-8164

REQUEST FOR MEDICATION ADMINISTRATION IN SCHOOL

(TO BE COMPLETED BY PHYSICIAN)

Name of Student: _____ DOB: _____

School: Longleaf School of the Arts

Diagnosis: _____

Medication: _____

(EACH MEDICATION MUST BE LISTED ON A SEPARATE FORM)

Dosage: _____ Route: _____

Time(s) medication is to be given: _____

To be given from: _____ to/through: _____

(DATE) **(DATE)**

Significant Information (to include side effects, toxic reactions, etc.):

_____

Contraindications to administration: _____

If an emergency 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 ADMINISTRATION (only used for Asthma, Diabetic and Anaphylaxis medications)

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

ASTHMA/ALLERGIC REACTION: MDI (metered dose inhaler) ____ MDI with spacer* _____
Epinephrine _____

DIABETES: Insulin Glucose

*Parent/guardian must provide an extra inhaler/epinephrine, injector/source of glucose to be kept at school in case of emergency and replace it when it expires.

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 the requirements stated in G.S. 115c-375.2. The student must also have a self-medication agreement on file.

This order remains in effect for the current academic year only and must be renewed each school year.

Date: _____ Physician's Signature: _____

Office Stamp:

OVER →

REQUEST FOR MEDICATION ADMINISTRATION IN SCHOOL

(TO BE COMPLETED BY PARENT)

PARENT'S PERMISSION

I understand that:

- The school nurse is the primary employee responsible for medication administration.
- Non-medical personnel *may conduct* the medication administration.
- It is my responsibility to have an adult parent/guardian to transport the medication to 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) and to replace the medication when it expires.
- It is my responsibility to remove this medication from the school on the last day of school, and that any medication left after the last day of school will be destroyed
- **If medication is not available at the school, 911 will be called for emergencies**

I request that:

- My child be administered the medication as indicated in the physician's order.
- My child be allowed to self-carry, if applicable, and self-administer their own emergency medication as indicated in the physician's order.

I hereby give my 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 all liability that may result from my child taking the prescribed medication.

HIPPA Consent

I authorize:

- The release and exchange of medical information between my child's physician and designated LSA staff members that is necessary in carrying out services for my child.

This consent is valid for the current school year, unless revoked.

Parent/Guardian Name: _____

(PLEASE PRINT)

Parent/Guardian Signature: _____

Telephone number(s): _____ Date: _____

Emergency contact number in case you cannot be reached: _____

(SCHOOL USE ONLY)

Approved by: _____ _____

School Nurse Date

Signature: _____