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____

Student allergies____

Student diagnosis____

____ ____________________________

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**__________________________