Authorization Form for Administering Drugs or Medication at School

School employees are authorized to administer drugs or medication only when the following conditions have been met:

1) The student's parent or legal custodian has made a written request that school personnel administer the drug or medication to the student and has given explicit written instructions describing the manner in which the drug or medication is to be administered;
2) A physician has prescribed the drug or medication for use by the student (for over-the-counter medications as well as medications available only by a physician's prescription);
3) A physician has certified that administration of the drug or medication to the student during the school day is necessary (for over-the-counter medications as well as medications available only by a physician's prescription);
4) The employee administers the drug or medication pursuant to the written instructions provided by the student's parent or legal custodian.

Student ______________________________ DOB _________ School _________________ Grade __________

List of Prescription Drugs

Name	Dosage	Time

List of Over-the-Counter Medications

Name	Dosage	Time

Note: Drugs and Medications must be sent in the original container(s) with specific written directions as to conditions prescribed for, dosage, and time of administration. For students with asthma, diabetes and/or anaphylactic reactions, the following permission is given to inhalers, insulin, or epinephrine auto-injectors:

☐ Student has been instructed, has demonstrated and understands the proper use his/her inhaler, insulin or epinephrine auto-injector and he/she should be allowed to carry it with him/her.

☐ Student should not be allowed to carry his/her medication.

I hereby give permission to authorized school personnel to administer the drugs and medications listed above during school hours pursuant to written directions. I hereby release the Dare County School Board, their agents and employees from all liability that may result from taking medication at school. My signature indicates that I have read and understand Policy 6125 Administering Medicines to Students.

Print Name of Parent/Guardian ___________________________________

Signature of Parent/Guardian ___________________________________

Date ______________________

Print Name of Physician ___________________________________

Signature of Physician ___________________________________

Date ______________________