RCHS Authorization for Medication Administration during the School Day by School Personnel

To be completed by parent/guardian:

Student Name: _____ Birth Date: _____ Grade: _____

Student's Physician: _____ Phone: _____ Fax: _____

Medication Allergies: [ ] No Known Drug Allergies [ ] Allergic to: _____

Medication requested to be given at school: _____

Has the child ever taken this medication before? [ ] Yes [ ] No (All first doses of medication must be administered at home)

I understand that all medication(s) must be in the original container and must be provided by the parent(s) or guardian(s). All medications must be kept in the nurse's office unless the student is cleared by both the physician and school nurse to self-carry. All narcotics/scheduled medication must be kept in the nurse's office at all times. First doses of medications shall not be given at school. No more than a 30 day supply of medications may be kept on campus.

I authorize the physician named above to release information regarding medication(s) my child will take during school hours, to Raleigh Charter High School. In addition, with my physician's permission, I agree my child may self-medicate (to include inhalers, epi-pens, diabetes care) at school.

I request that the designated personnel of Raleigh Charter High School administer medication to my child, named above, according to written physician's instructions and for the school nurse to exchange information with the physician regarding medication and health related issues. I understand it is my parental responsibility to furnish an adequate supply of this medication in the original and properly labeled container. I will notify the school immediately if the health status of my child changes, we change physicians, or the medication is changed or cancelled. I understand that school personnel will protect my child by not administering the medication if this form is not complete or the prescribed medication is not provided.

Parent Printed Name: _____ Phone: _____

Parent Signature: _____ Date: _____

To be completed by Physician:

Please be sure to provide action plans for seizures, asthma, and severe allergies

Medication Allergies: [ ] NKDA [ ] Allergic to: _____

Medication: _____ Dose (mg not tablets): _____

Route: _____ Time(s) to be administered at school: _____

Dates to be administered: _____ OR [ ] Entire School Year

If PRN, describe indication: _____ May repeat PRN dose after: _____

Condition for which the medication is required: _____

Special instructions or known side effects of medication:_____

Student is authorized to self-carry and self-medicate (inhalers, epi-pens, and diabetes care) [ ] Yes [ ] No

I verify the above medication information is accurate and needs to be administered during school hours for the student listed.

Physician Name: _____ Signature: _____ Date: _____