

# THE ACADEMY OF MOORE COUNTY

## Request for Administration of Medicine

***NOTICE TO PARENTS: The parent/legal guardian must bring medication to school in a container that is appropriately labeled by the pharmacy or physician.***

Date: \_\_\_\_\_  
Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Student's Diagnosis: \_\_\_\_\_  
Medication: \_\_\_\_\_  
Dosage: \_\_\_\_\_ Time of Administration: \_\_\_\_\_  
Route of Administration and Instructions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Physician's Name (please print): \_\_\_\_\_  
Physician's Signature: \_\_\_\_\_  
Physician's Phone Number: \_\_\_\_\_

***PARENT/LEGAL GUARDIAN: I hereby give permission for the school to administer the medication as prescribed above. I also give permission for the school to contact the above health care provider regarding the administration of this medication.***

Signature - Parent/Legal Guardian: \_\_\_\_\_  
Print Name – Parent/Legal Guardian: \_\_\_\_\_  
Home Phone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_  
Work Phone Number: \_\_\_\_\_

### **GUIDELINES FOR PRESCRIBING MEDICATIONS TO BE ADMINISTERED TO STUDENTS DURING THE SCHOOL DAY**

We welcome your support in providing services to our students. When prescribing medications for school age children, kindly consider the following requests and policies:

1. Whenever possible, avoid prescribing medication for administration during school hours, especially medications to be administered for a short period of time.
2. Schools are required to have appropriately labeled pharmacy/physician containers. These will be kept under lock and key in the school clinics.
3. Carrying of inhalers on the person is discouraged, unless ordered by a physician, because such items are easily stolen, lost, or forgotten at home, leaving the student in a dilemma and possibly in a medical crisis.
4. Any change of prescriptions requires a new written order from the prescribing physician.
5. Schools are readily available by FAX for quick communication.
6. Students are not allowed to transport medication on their person to and from school

Thank you for helping us provide the best possible services for students taking medications.

**PARENT’S PERMISSION**

I hereby give my permission for my child \_\_\_\_\_ to receive medication during school hours. This medication has been ordered and prescribed by a licensed physician. I hereby grant permission for the school nurse to communicate with the prescribing physician about the medication prescribed. I hereby release The Academy of Moore County and their Board of Directors from all liability that may result from my child taking the prescribed medication. This consent is good for one year, and may be revoked at any time.

I will furnish all medications 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/frequency it is to be given or taken). All over the counter medications will include the order for administration (first part of this authorization form signed by the doctor) with the identifying information, (name of child, medication dispensed, dosage prescribed according to label, and the time it is to be give or taken), with the medication in the original container.

I will replace this medication when it expires.

I will remove this medication from the school the last day of school. I understand medication not picked up will be destroyed after the last day of school.

Parent or Guardian Signature: \_\_\_\_\_

Telephone number(s): \_\_\_\_\_

Emergency contact number in case you cannot be reached: \_\_\_\_\_

\_\_\_\_\_

**STUDENT COMPETENCE CHECKLIST WITH NURSE FOR SELF ADMINISTERED MEDICATION**

\_\_\_\_\_ I have verbalized the name of my medication, informed the nurse of how it is prescribed and demonstrated competency in using this medication.

\_\_\_\_\_ I will use this medication (and any accompanying equipment) only as directed by my health care practitioner.

\_\_\_\_\_ I will not share my medication with anyone. Sharing medication or using it other than prescribed will result in disciplinary action.

\_\_\_\_\_ I will notify a teacher or staff member if I am having difficulty or need to see the nurse.

\_\_\_\_\_ I will keep my medication with me at all times while in school – **Location:** \_\_\_\_\_

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Signature of Nurse

\_\_\_\_\_  
Date