



Request For Medication (Prescription and Over-the-Counter) To Be Given During School Hours Or On School Sponsored Overnight or Extended Field Trips

Student _____ Date of Birth _____ Grade __ Allergies _____

Medication _____ Dosage _____ (No injection will be given except in extreme emergency, such as allergic reaction or asthma.)

Time of medication administration: AM. ___ PM. ___ Start Date _____ End Date _____

Special instructions or possible adverse reactions:
(Please list) _____

- School to administer medication
- If prescription is for EPI-PEN, INHALER or INSULIN student may self-carry and self-administer the medicine. I have provided education and he/she is knowledgeable and has demonstrated the necessary skill level for this medication.

Physician's Signature _____

Date _____

Telephone Number _____

PARENT'S PERMISSION

I hereby give my permission for my child (named above) to receive medication during school hours. I understand that in many cases non-medical personnel will administer the medication. A licensed physician has prescribed this medication and I hereby release the School Board, their agents and employees from all liability that may result from my child taking the prescribed medication.

I will furnish this medication in a container properly labeled by a pharmacist with identifying information (i.e.name of child, medication dispensed, dosage prescribed, and the time it is to be given.)

Parent or Guardian Signature _____

Date _____

Telephone number _____

The Form and Medication must be returned to the school nurse one week prior to the field trip.

- Junior High/High School 2527 Highway 221A Mooresboro, NC 28114-7698 Fax: 828-202-5135
- Grammar School 1110 South Broadway Forest City, NC 28043 Fax: 828-245-9530

Reviewed By: _____

School Nurse Signature

Date