Nash County Public Schools
Student Health Services **Medication Authorization**

Front (doctor) and back (parent) must be completed. Incomplete forms will NOT be accepted.

Student:_____ **DOB:**_____ **School Year:**_____

Daily or PRN Medications

(one daily medication and/or PRN medication order per sheet)

Daily and PRN medications MAY NOT be self-administered or self-carried by students

Diagnosis	Medication	Dosage	Route	Time(s) to give
Daily medication for:				
PRN medication for:				

Emergency Medications

(may order multiple medications per sheet)

Physician Authorization for Student to Self-Administer Emergency Medication O **Yes** O **No**

Adult supervision is NOT needed. The student has been instructed in the treatment plan, self-administration for the listed medication(s), and has demonstrated the skill level necessary to self-administer the medication.

Diagnosis	Medication	Dosage	Route	Time(s) to give
Allergic to:	O Diphenhydramine O Other:	O 12.5 mg O 25 mg O Other:	By Mouth	O Upon Exposure O Mild Reaction
Allergic to:	Epinephrine Auto Injector	O 0.15 mg O 0.3 mg	Intramuscular	O Upon Exposure O Severe reaction or more than 1 mild symptom O If provided, repeat dose after 5 min. for continued symptoms
Seizures	O Diazepam O Midazolam: O Other:	O 5.0 mg O 7.5 mg O 10.0 mg O 15.0 mg O 20.0 mg O Other:	O Intranasal O By Mouth O Buccal O Rectal	O At onset of seizure O Seizure > 5 min. O Seizure > 10 min. O Other:
Diabetes	O Glucagon: O Other:	O 0.5mg O 1.0mg O 3.0mg	O Intramuscular O Subcutaneous O Intranasal O	If student is unable to safely swallow or becomes unconscious
Asthma: Yellow Zone	O Albuterol O Other:	O 2 puffs O 4 puffs	O Inhaler w/spacer if provided	O Every 4 hrs. as needed to relieve symptoms. O Other:
Asthma: Red Zone **Call 9-1-1 and Parent**	O Albuterol O Other:	O 4 puffs	O Inhaler w/spacer if provided	For emergency symptoms O May repeat every 20 min. x 3 doses
Asthma: Additional instructions if needed	O Albuterol O Other:	_____ puffs	O Inhaler w/spacer if provided	When to give:
Asthma: O **Symbicort** O **Dulera**	**Yellow Zone:** 1 puff inhaled every 5 min as needed for cough, wheeze, SOB, up to 4 puffs. Call parent/guardian if not improved after 4 puffs			
	Red Zone: Call 911. Give 1 puff inhaled every 5 min. up to 12 puffs			

I CERTIFY THAT ADMINISTRATION OF THE PRESCRIBED MEDICATION(S) TO THE STUDENT <u>DURING THE SCHOOL DAY</u> IS NECESSARY TO MAINTAIN AND SUPPORT THE STUDENT'S CONTINUED PRESENCE IN SCHOOL OR AT SCHOOL SPONSORED EVENTS.

Physician/HCP Signature: _____Name *(printed)*: _____

Date: _____ Telephone: _____ Fax: _____

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Student:_____ DOB:_____ School Year:_____

Parent/Guardian:

I understand that:

- Only emergency, diabetes care and cystic fibrosis medications may be self-administered and/or self-carried
- Non-medical personnel may conduct the medication administration.
- It is my responsibility to have an adult transport the medication to school.
- Medication must be provided in the original pharmacy labeled container with directions for administration. If medication is available over-the-counter, it must be provided in the original container/packaging, labeled with the student's name.
- Unused medications not picked up by the end of school year will be discarded.
- If medication is not available at the school, 9-1-1 will be called for emergencies.
- If my child participates in NCPS before/after-school sponsored activities/sports, I will assume responsibility for contacting the advisor/coach of my child's medical condition. I will provide extra emergency medications that may be needed during the activity. I may contact the school nurse if assistance is needed in instructing the advisor in a medical procedure or if a copy of the information needs to be shared with them.

I request that:

- My child be administered the medication(s) as indicated in the healthcare provider's orders.
- If an emergency injection is ordered, I give permission for the school nurse to instruct designated staff in the administration technique.

I authorize:

- The release and exchange of medical information between my child's healthcare provider, school nurse, and the Nash County Public School System that is necessary in carrying out services for my child.

I hereby give permission:

For my child to receive medication during school hours. A licensed healthcare provider has prescribed the medication.

If self-administration/carry is prescribed: I give permission for my child to carry and administer the emergency medication listed on the reverse side during the school day, at school-sponsored activities, or while in transit to or from school. Adult supervision is not needed and I understand that:

- I will provide back-up medications to be kept at the school (in addition to what my child will carry) _____ *parent initials*
- My child will be required to demonstrate the skill level necessary to self-administer the medication. _____ *parent initials*
- My child will be subject to disciplinary action if medication is used in any manner other than prescribed. _____ *parent initials*

I hereby release the Nash County Public Schools Board of Education and their agents and employees from any and all liability that may result from my child taking the prescribed medication.

Parent/Guardian Signature: _____ Print Name:_____

Phone: _____ Date:_____

Student*:* self-carry/administer authorized

I will keep my medication and equipment with me at school and school-sponsored activities.
I will *only* use the medication as prescribed by my healthcare provider.
My medication will be kept in the original container labeled with my name.
I will *not* allow any other person to use my medication.
I will notify a school staff member if I am having more difficulty than usual with my health condition.

Student signature: _____ Date: _____

I have observed the student verbalize and demonstrate the knowledge, ability, and skill level necessary to use the medication as prescribed by the healthcare provider. Circle: Inhaler Epinephrine Auto Injector Cystic Fibrosis Medication

Nurse Signature: _____Date: _____

Nurse Signature: _____ Date received and reviewed: _____