POLK COUNTY SCHOOLS (PCS)

MEDICATION AUTHORIZATION/REQUEST FORM

HEALTHCARE PROVIDER only:

Medication _____ Strength/Dose_____

Specific Directions– please include exact amount to give, at what time and /or how often, any special indications, e.g. if as needed.

Purpose of Medication: _____ **How Often and What Time:** _____

Specify side effects or adverse reactions: _____

Please check all appropriate item. If either of the first two items is checked page 2 of this form *must* be completed.

- ❑ Please allow this student to self-administer this medication while at school, during school hours
- ❑ This student should carry the medication with him/her at all times during the school day, while at school-sponsored events, or while in transit to or from school-sponsored activities.
- ❑ This medication is for used for emergencies only.

_____ _____ _____ _____

Signature of Health Care Provider **Date** **Telephone** **Fax #**

_____ _____ _____

Please PRINT Providers name **Practice Name/Address**

Parent/Guardian of _____ (Student Name) Birth Date_____

In order to help protect your child's health; your consent AND written authorization from a licensed healthcare provider are REQUIRED when it is necessary for your child to receive either prescription or NON- prescription medications in Polk County Schools. No medication will be given to your child at school until this authorization has been received. A separate form is required for each medication. New authorization forms are required every year at the beginning of school, whenever the dose or directions change or a new medication is prescribed. It is your responsibility to provide all medicines to be given a school. Each medication must be in the correctly labeled original container either from pharmacy or over the counter packaging/bottle.

PARENT OR GUARDIAN'S PERMISSION: I give permission for my child to receive the medicine prescribed during school hours. On behalf of my child, I release Polk County School Board, their agents, and employees from all liability that may result from my child taking the prescribed medication. I give permission for the school nurse to contact my child's physician regarding their medication or health condition if necessary.

_____ _____ _____

Signature or Parent or Guardian **Date** **Contact Telephone Number**

School	Check one	Telephone	Fax #	School	Check one	Telephone	Fax #
PC Virtual Early College		828-894-2698	828-8942971	Preschool (Pre-K)		828-894-3051	828-894-8153
PC High School		828-894-2525	828-894-2093	Saluda		828-749-5571	828-749-1106
Polk Central		828-894-8233	828-894-3916	Sunny View		828-625-4530	828-625-8409
Polk County Middle		828-894-2215	828-894-0191	Tryon Elem		828-859-8654	828-859-6170

Date Received: _____ School Nurse Review: _____

POLK COUNTY SCHOOLS (PCS)

Self -Administration of Medications

Student Name_____ Birth Date: _____

Medication: _____ for _____

HEALTH CARE PROVIDER's only

Asthma inhalers, Epi-Pens and diabetic supplies may be carried and self administered according to North Carolina law with a health care provider's (HCP) signature.

- ❑ _____ (HCP Signature), I agree this student demonstrates the knowledge and skill necessary to self medicate (limited to asthma inhalers, EpiPen, and/or Diabetic supplies).

Parent Section

I give consent for my child to possess and self-administer this medication at school. I understand that my child and I assume responsibility for the proper use and safekeeping of this medicine. I absolve the school board, its agents and employees from any and all liability whatsoever that may result form my child possessing or taking this medication at school.

Parent/Guardian Signature: _____ Date: _____

Student Section

I am capable of taking this medicine as recommended and accept this responsibility. I will keep it secure at all times and will not share it with others. I understand that I will be subject to disciplinary action if I abuse the privilege of being allowed to carry and self-medicate while at school or during school sponsored activities.

Student Signature: _____ Date: _____

SCHOOL NURSE SECTION

I have reviewed this request and agree this student has demonstrated he/she understands when and how to self-administer this medication.

School Nurse Signature: _____ Date: _____