PERSON COUNTY SCHOOLS MEDICATION ADMINISTRATION ORDER

School _____

This order is valid for the _____ school year

Student's Name _____ Birth Date _____Grade_____

Prescriber's Name (please print) _____

Prescriber's office phone # _____ Prescriber's fax # _____

Name of Medication _____ Dosage _____

Time(s) to administer _____ AM / PM _____ AM / PM

Or every _____hours as needed for _____

Begin medication on _____ Discontinue medication on _____

Possible side effects _____

Reason for medication _____ICD 9 Code_____

Contraindications _____

I. SELF-CARRY/SELF-ADMINISTER MEDICATION

PERMISSION TO SELF-CARRY/SELF-ADMINISTER ASTHMA INHALER:

This student has asthma and should be allowed to carry the asthma medication prescribed above on their person for use on school property during the school day, at school sponsored events or while in transit to or from school or school sponsored events. I confirm that this student understands and has been instructed in self-administration, and has demonstrated the necessary skill level to self administer this medication.

Prescriber's signature _____ Date _____

PERMISSION TO SELF-CARRY/ SELF-ADMINISTER EPINEPHRINE AUTO-INJECTOR:

This student has an allergy that could result in an anaphylactic reaction and should be allowed to carry the medication prescribed above on their person for use on school property during the school day, at school sponsored events, or while in transit to or from school or school sponsored events. I confirm that this student understands and has been instructed in self-administration, and has demonstrated the necessary skill level to self administer this medication.

Prescriber's signature _____ Date _____

PARENT AUTHORIZATION: SELF-CARRY/SELF-ADMINISTRATION OF ASTHMA INHALER/EPINEPHRINE AUTO-INJECTOR

I authorize my child (named above) to possess and self-administer this prescribed asthma medication and/or epinephrine auto-injector. I release the Board of Education, its employees, and agents from any liability that may be associated with my child possessing and/or self-administering this medication.

Parent's signature _____ Date _____

II. SCHOOL STAFF ADMINISTRATION OF MEDICATION

PRESCRIBER'S AUTHORIZATION:

I have prescribed this medication for the condition above and it is necessary that this medication be administered during the school day.

Prescriber's signature _____Date_____

PARENTAL AUTHORIZATION:

I request that school personnel administer the above prescribed medication to my child during the school day. I hereby release the Board of Education, their agents, and employees from any and all liability that may result from my child taking this medication.

Parent / Guardian signature _____ Date_____