CURRITUCK COUNTY SCHOOLS
PERMISSION TO ADMINISTER MEDICATION

STUDENT'S NAME:_____ DATE:_____

SCHOOL:_____TEACHER/GRADE:_____

PHYSICIAN'S NAME & PHONE #:_____

The Currituck County School System discourages administration of medications in the schools. However, if a physician decides it is necessary for a student to receive medication during the school day, and a parent is unable to make other arrangements, we must have authorization and specific instructions from that physician. The following information **must** be provided before any prescription or over the counter medication can be administered at school.

Medication:_____ Color:_____
(include trade name prescription #) (if applicable)

Tablet Ointment Capsule Inhalation Liquid Other

Other (specify): _____
Dosage (amount to be given): _____
Relationship to meals: _____
How often or at what time: _____
Side Effects (expected or predictable): _____
What to do if side effects occur: _____

No injection will be given except in extreme emergency, such as allergy to wasp or bee sting. In order to keep this child in optimum health and to help maintain maximum school attendance and performance, it is necessary that a drug or medication to given during school hours.

_____ _____
Physician's Signature Date

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PARENT'S PERMISSION

I request and give permission for the school to administer the above drug or medication prescribed by my child's physician to be given during school hours. I hereby release the School Board and its agents and employees from any and all liability that may result from the administration of the above drug or medication.

I agree to send the drug or medication in a properly labeled container from the pharmacy.

_____ _____
Parent or Guardian Signature Telephone Number