REQUEST FOR MEDICATION TO BE GIVEN DURING SCHOOL HOURS

FORM 1 (page1) PARENT REQUEST FOR MEDICATION ADMINISTRATION AT SCHOOL/PHYSICIAN'S ORDER

This form should be used only when school personnel will be administering medication to your child.
If your child will be possessing and self-administering his/her medication, please request Form 2.

Child's Name: _____ **DOB:** _____ **School:** _____

Dear Parent/Guardian:

In order to help protect your child's health, your consent and written authorization from a doctor are required when it is necessary for your child to be administered either prescription or non-prescription medicines in the Durham Public Schools. No medications will be administered to your child at school until this authorization has been received. A separate form is required for each medicine. New authorization forms are required every year at the beginning of school, whenever the dose or directions change, or when a new medicine is prescribed. Each medicine must be in an appropriately labeled original container from the pharmacy or healthcare provider's office. Most pharmacies will provide an extra container for school use upon request. Administration of nonprescription medicines at school is discouraged.

I, _____, understand that:

- It is my responsibility to purchase and supply all medicines to be given at school.
- The Durham Public Schools Board of Education and its employees and agents authorized to administer drugs or medication prescribed by a doctor upon my written request shall not be liable in civil damages for any administration or for any omission relating to the administration, unless that act or omission amounts to gross negligence, wanton conduct, or intentional wrongdoing.
- Information shared may be in the form of an emergency or individual care plan for my child and may include information provided by my child's physician, myself, or from records that have been released to the school from another agency.
- Exchange of information will be limited to the minimum necessary to provide the required assistance for my child and will be shared only with those staff who may need to provide the specified assistance for him/her.
- This consent to release information must be signed before my child's teachers can provide assistance with special medical needs other than notifying parents and providing Emergency Services (911).
- If my child participates in DPS before/after-school activities/sports, I will assume responsibility for notifying the advisor/coach of my child's medical condition. Since the medication kept by the school is only available during regular school hours, I will provide extra emergency medication 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, _____, authorize the release and exchange of medical information between my child's physician, school nurse and Durham Public Schools that is necessary in carrying out services for my child, _____ _____. I, _____, also hereby give permission for my child _____ to be administered the specified medication indicated by his/her physician on the reverse. I understand that non-medical personnel conduct the administration. If an emergency injection is ordered, I give permission for the School Based Public Health Nurse to instruct designated staff in the administration technique. I understand that it is my responsibility to transport the medication to school unless special arrangements are made with the principal.

_____ _____ _____
Parent/Guardian Signature Contact Information (home/work/cell) Date

To be completed by school:

Date Received from Parent/Guardian: _____

PLEASE IDENTIFY BELOW THE NAMES OF ALL DPS EMPLOYEES DESIGNATED and TRAINED TO ADMINISTER MEDICATION TO STUDENTS IN YOUR SCHOOL.

Name _____ Title _____ Name _____ Title _____

Name _____ Title _____ Name _____ Title _____

Name _____ Title _____ Name _____ Title _____

Signature of Principal _____ Date _____

REQUEST FOR MEDICATION TO BE GIVEN DURING SCHOOL HOURS

FORM 1 (page 2) PARENT REQUEST FOR MEDICATION ADMINISTRATION AT SCHOOL/PHYSICIAN'S ORDER

Child's Name: **DOB:**

School Name: **Phone:** **Fax:**

FOR PHYSICIAN USE ONLY: ***PLEASE WRITE LEGIBLY USING LAY TERMS***
Medication prescribed: Strength/Dose:
Specific Directions [Include exact amount to give, at what time and/or how often, relationship to meals, specific indications, e.g. if pm (as needed)]: Purpose of Medication:
Relationship to meals, if applicable:
How often and at what time (hour):
Specify side effects or adverse reactions:
Other instructions (including emergency situations):
☐ Please check if this medication is to be used for emergencies only.
It is necessary for this student to receive this medication during school hours in order to maintain or improve health and to benefit from school attendance.
Signature of Healthcare Provider Date Telephone Fax
Please print Provider's last name **Practice name/address**

Parent/Guardian Signature _____ Date_____

FOR SCHOOL USE ONLY:

Date Received By: School Nurse Review: