Washington Montessori
Public Charter School
2330 Old Bath Hwy.
Washington, NC 27889
Phone: (252) 946-1977 Fax: (252) 946-5938
www.wmpcs.org

Request for Medication Administration in School

To be completed by physician:

Name of Student:__________________________________ School:____

Medication:____ Dosage:__________________________________

Time(s) medication is to be given: a.m.____   p.m.______ To be given from: (date)___________ to_______________
Significant Information (include side effects, toxic reactions, omission reactions):_______________________________

____

Contraindications for Administration:____
____

If an emergency situation occurs during the school day or if the student becomes ill, school officials are to:

a. Contact me at my office___________________________ Telephone___________________________

b. Take child immediately to the emergency room at____

A written statement, treatment plan and written emergency protocol developed by the student's health care provider must accompany this authorization form in accordance with requirements stated in G.S. 115C –375.2

All prescription medication for use at school will be furnished by parent or guardian in a container properly labeled by a pharmacist and over the counter medicine must be in the original container. All medicines must have identifying information, (e.g., name of child, medication dispensed, dosage prescribed, and the time it is to be given or taken).

_______________________________________ Date__________________________
Physician's Signature

PARENT'S PERMISSION
I hereby give my permission for my child (named above) to receive medication during school hours. This medication has been prescribed by a licensed physician. I hereby release the School Board and their agents and employees from all liability that may result from my child taking the prescribed medication. This consent is good for the school year, unless revoked.

__________________________________ ____________________________ __________________________________
Parent or Guardian's Signature   Telephone Number   Date

School Use Only

Name and title of person to administer medication (unless self-administered)
____

Approved by____ _______________________________
Administration School's Signature   Date