

Cleveland County Schools

Request For Medication To Be Given During School Hours

In order for Cleveland County School Employees or School Health Services Staff to administer medication in the school setting and at school sponsored activities an up-to-date Health Care Provider's order must be on file.

Health Care Provider's Order

Name of student _____ D.O.B. _____ Grade _____
Medication _____ Dose _____ Frequency _____
Time(s) medication is to be given: _____ AM _____ PM
Date to begin: _____ Date to end: _____
Significant Information: (include medical condition, side effects, toxic reactions, omission reactions, etc.)

Contraindications for Administration: _____
Comments: _____

Special instructions for asthma/respiratory medications. Administer _____ puffs/nebulizer treatments (circle one) every _____ minutes/hours (circle one). May repeat up to _____ times. Other _____

Initial here to indicate that student is to self-medicate and carry medication at school: _____
(Self-medication must be for treatment of asthma, anaphylaxis, or diabetes) Health Care Provider's Initials

Health Care Provider's Signature/Date

Health Care Provider's Office Address

Health Care Provider's Name (printed)

Health Care Provider's Telephone Number

Prescription medication must be supplied in a pharmacy labeled container with identifying information (name of child, name of medication, dosage, and time it is to be given). Over-the-counter medication must be supplied in a new, unopened container. No injection will be given except in extreme emergency or if the student's health condition necessitates that an injection be given during school hours.

Parent's Permission

I hereby give permission for my child (named above) to receive medication during school hours. I understand that in most cases non-medical personnel conduct the administration. If an emergency injection is ordered, I give permission for the school nurse to instruct designated staff in the administration technique. This medication has been prescribed by a licensed Health Care Provider. I hereby release the School Board and their agent and employees from any and all liability that may result from my child taking the prescribed medication, or from possessing and self-administering asthma medication, Diabetic medication or EpiPen® as ordered by a licensed Health Care Provider.

Parent/Guardian's Signature Telephone Number Date
If an emergency occurs during the school day or if my child becomes ill, school officials are to:
Contact: _____ Phone# _____
Name/Relation