Caswell County Schools
Authorization for Medication Administration

PHYSICIAN: COMPLETE ALL ITEMS IN BOLD

Student's Name:_____ **Date of Birth:** ____/____/____

School:_____ Telephone:_____ Fax:_____

Medication:_____ **Dosage:**_____ **Route:**_____ **Frequency:**_____
(No injection will be given **except** in extreme emergency, such as allergy to wasp or bee sting.)

Time(s) medication is to be given:_____ **Dates to be given from:** ____/____/____ **to** ____/____/____
(Medication request will be in effect until the beginning of the next school year unless otherwise specified)

Type of medication: (circle) Tablet Capsule Liquid Inhalation Ointment Injection Other _____

Significant Information (side effect, adverse & 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: _____

This medication will be furnished by parent or guardian in a container properly labeled by a pharmacist with identifying information (e.g., name of child, medication dispensed, dosage prescribed and the time to be given.)

Physician's Signature: _____ **Telephone:** _____ **Date:** ___/___/___

PARENT'S PERMISSION

I hereby give 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.

Parent/Guardian Signature _____ Telephone: _____ Date: ___/___/___

----------(SCHOOL USE ONLY)----------

Name and title of person to administer medication: _____

Approved by: _____(Principal's Signature) _____(Date)

Reviewed by: _____(School Nurse's Signature) _____(Date)

MEDICATION CHECK-IN & SIGN-OUT LOG

Date	Medication	Amt. Rec'd	Received by (signature)	Received from (signature)