WASHINGTON COUNTY SCHOOLS
MEDICATION AUTHORIZATION FORM

Washington County Middle School 252- 793-2835 Fax 252-793-4411
Washington County High School 252-793-3031 Fax 252-793-3986
Washington County Early College 252-797-4766 Fax 252-797-4651
Pines Elementary 252-793-1137 Fax 252-793-4411 Pines NCPK 252-793-1327 Fax 252-793-1350
Creswell Elementary 252-797-7474 Fax 252-797-7343

TO BE COMPLETED BY THE HEALTH CARE PROVIDER:

Name of Child ___________________________________ Date of Birth _______________________

Medication/Strength ______________________________ Dosage to be Given __________________

Time to be Given ___________________________ Route of Administration ___________________

Diagnosis ___________________________ Side Effects ____________________________________

Duration of Order (no longer than duration of school year) ___________________________________

Physician Name _________________________________ Phone __________________

Physician Signature ______________________________ Date __________________

EMERGENCY MEDICATIONS:

Washington County School board policy allows students with asthma, diabetes, and/or those subject to anaphylactic reactions to carry and self-administer emergency medications, such as inhalers, insulin and epinephrine auto-injectors. These are the only medications that students are allowed to carry. All other medications will be administered by school staff.

*Physician: If this is an emergency medication and the student is allowed to self-administer this medication at school, please initial here. _______

PARENT/GUARDIAN TO COMPLETE :

I hereby give consent for the following:
_____ School staff may administer the medication to my child according to the physician's directions above. _____ My child may self-medicate, using the prescribed emergency medication, according to the physicians directions above.
The school nurses at Washington County Schools have my permission to contact the physician should there be any questions or concerns regarding this medication. I understand that this medication must be delivered to school personnel by the parent/guardian and that students are NOT to transport medication, unless it is an approved emergency medication. I understand that this medicine must be in the original, labeled container. The medication provided must match the physicians order. I hereby release the School Board, their agents, and employees from any and all liability that may result from my child taking this medication.

Parent/Guardian Signature __________________________________ Date _______________

Parent/Guardian Phone: Home _____________ Cell _____________ Work _______________
School Nurse Signature _________________________________ Date _____________