Lincoln County Schools
P.O. Box 400, Lincolnton, NC 28093-0400

Request for Medication to be Given During School Hours

SCHOOL TO PLACE PHOTO HERE IF AVAILABLE

To be completed by physician

Name of Student__________________________ School____

Medication________________________________ Dosage/Route________________________________
(No injection will be given except in extreme emergency, such as allergy to bee stings)

Time(s) medication is to be given at school a.m. ____________________ p.m.___________________

To be given from (date)________________________________to (date) ____________________________

Significant Information: (e.g., purpose of medication, side effects, any special instructions for giving meds at school, contraindications)

Would it be acceptable to keep the medication in the school's main office?_______________________________

This medication will be furnished by parent/ guardian within a container properly labeled by a pharmacist with identifying information, (e.g., name of the child, medication dispensed, dosage prescribed, and the time it is to be given). Over-the-counter medications will be in the original container labeled with the student's full name.

Physician's Signature____________________________________***Date***__________________________________

Group Name________________________Phone#_________________________Fax#_____________________

Physician is to complete this box ONLY if student is to carry and self medicate with inhaler or epinephrine auto-injector.

I feel that it is medically necessary for the above named student to carry his/her own medication and self-medicate as prescribed. I have provided education to the student on indications for the use of the medication and methods of administration.

Physician's Signature_____________________________**Date**____________________________

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Parent's Permission

I hereby give my permission for my child (named above) to receive medication during school hours. I understand that the school undertakes no responsibility for the administration of the medication. I also understand that this medication will be disposed of at the expiration date of this order. Medication orders are only good for the length of the school year. Please make every effort to pick up your child's medication the last day of school. This medication has been prescribed by a licensed physician. I hereby release the School Board and their agents and employees from any and all liability that may result from my child taking the prescribed medication.

Reviewed by School Nurse:
(signature/date
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Signature of Parent/Guardian & Telephone Number

__________________________ __________________________
Expiration Date of Medicine Date

Revised 7/2014 LCSN