

Medication Administration Authorization



3106 NC Hwy. 54, Durham, NC 27713
(919) 998-6757
www.researchtrianglehighschool.org

Student Name : _____
(First Middle Last)

Medication Administration Policy

- Students are not permitted to carry medication or self-medicate on school property.
- Non-medical personnel conduct the medication administration. This policy is necessary to ensure accuracy and the safety of students who need medication while at school. There will be no exceptions made. We ask that parents request school assistance with medications only when absolutely necessary.
- If a student needs to take medication (prescription or over-the-counter) during the school day, a parent may choose to:
 1. Come to school and give the medication to the student, OR
 2. Bring a supply of the medication to the front office in its original container along with this completed form. Prescription medication must be properly labeled by a pharmacist with identifying information (Rx number, name of student, name of medication, proper dosage, and directions for administration).
- It is the student's responsibility to come to the front office at the specified time to receive the medication from a staff member.
- Medication must be taken in the presence of a staff member.
- The student must sign the medication log.
- Any medication that has not been retrieved by the parent/guardian by the last day of school will be disposed of by school personnel.

Physician Section

1. **Diagnosis** : _____ **Name of Medication** : _____
Dosage Amount : _____ **Dosage Time** : _____
2. **Diagnosis** : _____ **Name of Medication** : _____
Dosage Amount : _____ **Dosage Time** : _____

Additional Information : _____

Emergency Medication (please describe, if applicable) : _____

Physician (print name) : _____ **Physician Stamp** : _____

Physician Signature : _____ **Date** : _____

Parent/Guardian Signature

I hereby give permission for my child, named above, to receive medication during school hours per the physician's instructions. I also agree to the terms of the Medication Authorization Policy and hereby release the School Board and its agents and employees from any and all liability that may result from the administration of medication.

Parent/Guardian Signature : _____ **Date** : _____