Union County Public Schools Medication Consent Form

School: Marvin Ridge MS Telephone: 704.290.1510 Fax: 704.243.0153

Student Name______________________________ Birthdate__________________

Teacher/Grade______________________________

In order to help protect your child's health, your consent **and** written authorization from a health care provider with prescriptive authority is required when it is necessary for your child to receive prescription and/or non-prescription medicines.

Parent or Guardian's Permission: I give permission for my child to receive this medicine during school hours. I also give permission for school staff to contact the prescribing healthcare provider with questions/concerns. I understand that it is my responsibility to purchase and supply this medicine in its original container. On behalf of my child I absolve the Union County School Board and their agents and employees from any and all liability whatsoever that may result from my child taking this medicine at school.

______________________________ ______________________________

Signature of parent or guardian Date Contact numbers (telephone, cell phone, pager, etc.)

☐ This medication is to be used for emergencies only. Please allow this student to self-administer this medication

*******Both sides of this form are required for emergency self carry medications*******

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Medication______________________________ Strength/Dose______________________

Medical Diagnosis: ____

Specific Directions (include amount to give, at what time and/or how often, relationship to meals, specific indications if "as needed")

How often and/or at what time (hour):______________________________

Purpose of medication: ______________________________

Relationship to meals, if applicable: ______________________________

Expected side effects or adverse reactions: ______________________________

Specific indications: ______________________________

Other information: ______________________________

It is necessary for this student to receive this medication during school hours in order to maintain or improve health and to benefit from school attendance. Please notify the principal and/or school nurse and parents/guardians if there are any problems.

______________________________ ______________ ______________

Signature of Healthcare Provider Date Telephone Fax

______________________________ ______________________________

Please print practitioner's last name **Practice name /address**

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FOR SCHOOL USE ONLY:

Date Received/By: ______________________________ School Health Nurse Review: ______________________

Location of Medicine ☐ on student, emergency medication only ☐ in Health room ☐ in Classroom

AUTHORIZATION FOR SELF-CARRY BY UCPS STUDENTS
EMERGENCY MEDICATIONS

Student's Name________________________________ Birthdate_______________

Medication________________________ for ______________________________

Eligibility: Only students with asthma, diabetes and/or severe allergies who may require rescue medications (i.e., inhaler, glucagon, insulin, epi-pen, benadryl).

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<u>Healthcare Provider:</u> This student is capable of and has been instructed on how to self-carry and, **if applicable**, administer this medication as directed on the medication consent form (both correct technique and dose intervals). Please allow him/her to self-carry it during school hours or activities. In the event of an emergency, this student may need assistance by a school staff member in the administration of this medication.

Healthcare Provider Signature/Date______________________________________

<u>Parent/Guardian</u>: I give consent to the Union County Public Schools to allow my child to self-carry and, when applicable, to self-administer this medicine at school. I understand that my child and I assume responsibility for the proper use and safekeeping of this medicine. <u>I will provide backup medication to be kept at school</u>. I absolve the Union County Board of Education and their agents and employees from any and all liability whatsoever that may result from my child carrying this medicine at school.

Parent Signature/Date ____

<u>Student:</u> I am capable of carrying this medicine as recommended and accept this responsibility. I will keep it secure at all times and will not share it with others. I understand that I will be subject to disciplinary actions if medications are shared.
I will inform an adult when medication is used.
Student Signature/Date ____

<u>School Health Nurse:</u> I have reviewed this request and agree that this student should be capable of safely self-carrying and, when applicable, self-administering this medication.

School Health Nurse Signature/Date ____________________________________

reviewed 7-2014 jsl