

The Woods Charter School
ADMINISTRATION OF MEDICATION DURING THE SCHOOL DAY

Date: _____

Student Name: _____ DOB: _____ Height _____ Weight _____

School Year: _____ Grade: _____ Teacher: _____

It is against school policy for students to have medications on their person. All medications will need a physician's prescription on file, and must be kept in the front office in a secure location. Please make an appointment with the front office if you wish to discuss your child's health concerns.

Exceptions are students who may carry emergency medications for asthma and/or severe allergies, etc., such as inhalers, epi-pen and glucagon. For these children, an additional form called "Student Agreement for Self-Carried Medications" must be completed prior to the start of the school year. This form is available in the front office.

- **FILL OUT THIS FORM FOR EACH MEDICATION TO BE ADMINISTERED.**
- **This form can be brought into school or faxed to Woods Charter at 919-960-0421**
- **Each medication must be in its original container, and should have: Student's name, Physician, medication name, dose, route, frequency, time and pharmacy name**

Physician's order for administration of medication by school personnel

Allergies: Medication and other: _____

Type of reaction _____

I have prescribed the following medication for the student named above and request that dosages be given during school:

Medication _____ Dose: _____ Route: _____

Time: _____ Frequency: _____

For treatment of: _____

Possible side effects: _____

Special instructions: _____

Other medication including over the counter the student is currently taking: _____

Physician's name (print) _____ Phone: _____

Physician's signature: _____ Date: _____

- **Parental request for administration of medication:**

I hereby give my permission for my child (named above) to receive medication during school hours. This medication has been prescribed by a licensed physician (health care provider). I assume full responsibility for informing the principal (or representative) of any changes in my child's health or medication. I release Woods Charter, their agents and employees from any and all liability that may result from my child taking the prescribed medication. I will furnish this medication with a container properly labeled by a pharmacist with identifying information (eg., name of child, medication dispensed, dosage prescribed, time and frequency to be given. I give authority to communicate with the ordering physician about this medication.

Parent/Guardian: (print) _____

Date: _____

Parent/Guardian (signature) _____