

**CAMDEN COUNTY SCHOOLS  
MEDICATION AUTHORIZATION FORM**

**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) \_\_\_\_\_

**EMERGENCY MEDICATIONS:**

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. \_\_\_\_\_

Physician Name \_\_\_\_\_ Phone \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

**TO BE COMPLETED BY PARENT/GUARDIAN:**

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 nurse has 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 \_\_\_\_\_**