Rowan-Salisbury
SCHOOL SYSTEM
Extraordinary Education Every Day

PHYSICIAN'S AUTHORIZATION FORM FOR PRESCRIPTION AND NON-PRESCRIPTION MEDICATION

Whenever possible medication should be administered at home. If a medication is to be administered by school personnel, a Physician's Authorization Form must be completed and signed by the prescribing physician and the parent. Prescription medication must be in the most current pharmacy labeled container. Over-the-counter medication must be provided in the original container with possible side effects listed. A new form must be completed each school year and anytime the dose or instructions change. Medication cannot be returned home with a student.

Student Name: ______________________ Date of Birth: ______________________

School: ______________________ Teacher/Grade: ______________________

Medication: ______________________
(ONE MEDICATION PER FORM)

Dose: ______________________ Relationship to meals: Before ☐ After ☐ N/A ☐

Type of Medication (Circle): Tablet/Capsule Inhalation Liquid Ointment Injection Other: ______________

Direction/Purpose of medication: ______________________

____

Time(s) medication is to be given at school: ______________________

Date medication is to start: ______________ Date medication is to end: ______________

Possible side effects (expected or predictable): ______________________

Time medication is administered at home: ______________________

SELF ADMINISTRATION OF MEDICATIONS (FOR PHYSICIAN'S USE ONLY)

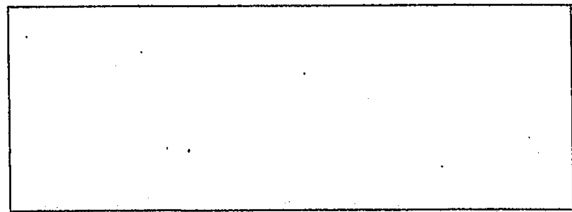
Asthma inhalers, epi-pens, and diabetic supplies may be carried & self-administered according to North Carolina State Law with a physician's signature.

☐ ______ **(Physician's Initials) I agree this student demonstrates the knowledge & skill necessary to self-medicate (limited to asthma inhalers, epi-pens, and diabetic supplies)**

To maintain this student's optimum health and to maximize educational performance and attendance, it is necessary that this medication be given during school hours according to the above instructions.

____
Physician's Signature

______________________ ______________
Telephone Number Date



Clinic Stamp

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I request that my child (named above) receive this medication as instructed above. I understand it is my responsibility to furnish this medication in the appropriate container to school. I give permission for the school nurse to contact my child's physician regarding their medication or health condition if necessary. I understand if any remaining medication is not picked up by the last day of school, it will be disposed of.

__________ ______________________ ______________________
Date Parent Signature Telephone Number

PARENT: PLEASE SEE BACK OF FORM

(REVISED 7/2014)

FOR PARENT REVIEW

In order to protect your child's health:

- ❖ Your consent and written authorization from a licensed healthcare provider are required when it is necessary for your child to receive either prescription or nonprescription medication in the Rowan-Salisbury School System.
- ❖ No medication will be given to your child until this authorization form has been received.
- ❖ A separate form is required for each medication.
- ❖ New authorization forms are required each school year, whenever the dose or directions change, or if a new medication is prescribed.
- ❖ It is your responsibility to furnish all medication to be given at school.
- ❖ Each prescription medication must be in the appropriately labeled pharmacy container. Most pharmacies will provide a second container for school if asked.
- ❖ Non-prescription medication must be in the original manufacturer's container with recommendations and side effects listed.

SELF MEDICATION SECTION

LIMITED TO APPROVED MEDICATION UNDER THE ROWAN-SALISBURY SCHOOL MEDICATION POLICY

Parent Section

I give consent for my child to possess & self-administer this medication at school. I understand that my child and I assume responsibility for the proper use and safekeeping of this medicine. I absolve the school board, its agents and employees from any and all liability whatsoever that may result from my child possessing or taking this medicine at school.

Parent/Guardian Signature: ______________________________

Date: ______________ Daytime telephone number: ______________________

Student Section

I am capable of taking 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 discipline under the Student Code of Conduct if I abuse the privilege of being allowed to carry and self-medicate while at school or during school sponsored activities.

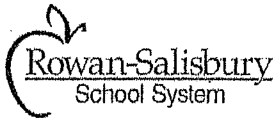
Student Signature: ______________________________ Date: ______________

School Nurse Section

I have reviewed this request & agree that this student has demonstrated he/she understands when & how to self-administer this medication.

School nurse or designee signature: ______________________________ Date: ______________

In compliance with federal law, the Rowan-Salisbury School System administers all education programs, employment activities, and admissions without discrimination because of race, religion, national or ethnic origin, color, age, military service, disability, or gender, except where exemption is appropriate and allowed by law.



Asthma Health History

Student: ________________________________ School:________________

Teacher/Grade: ____________________________ School Year:____________

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Physician treating student for asthma: ____________________ Phone________________

Yes No Has your child been seen in the Emergency Room or hospitalized for asthma in the past year? Date: ________ Where? ________________

Yes No Has your child seen the doctor in the past 12 months for asthma?

Yes No Is you child aware of actions to take during an asthma attack?

Yes No Does your child use medications to treat or prevent asthma?

Yes No Will asthma medications be needed for school?

Please list medications: ____

____

Identify triggers that start an asthma episode (check all that apply to the student)

- ☐ Exercise
- ☐ Illness
- ☐ Temperature change
- ☐ Strong odors/fumes
- ☐ Dust/chalk dust
- ☐ Carpets
- ☐ Mold
- ☐ Pollens
- ☐ Animals
- ☐ Food (list) ____
- ☐ Other (list) ____

List your child's symptoms: ____

Emergency action is necessary when the student has the following symptoms: ______________

____

Parent Signature ____________________________ Daytime Phone ________________________

School Nurse Signature ____________________________________ Date ______________

Revised April 2011

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Asthma Emergency Action Plan

Student____ DOB ____________________

STEPS TO TAKE DURING AN ASTHMA EPISODE

GREEN ZONE: NO SYMPTOMS

Breathing is good
No cough or wheeze
OK to play

YELLOW ZONE: CAUTION!

Coughing
Wheezing
Tight chest

What to do:

1. Stay with the student and attempt to calm.
2. Have the student rest in a sitting position, breathing slowly through mouth and exhaling slowly through pursed lips.
3. Have the student take their prescribed medication per RSSS Policy and physician's orders. **The student should respond to medication within 15 – 20 minutes.**
4. Notify the parent/guardian of severe breathing difficulty or if medication is not effective within 15 minutes.

RED ZONE: DANGER!

Medicine is not helping
Breathing is hard and fast
Nose opens wide
Can't walk
Can't talk well

What to do:

1. Call parent/guardian
2. If unable to reach parent/guardian, CALL 911.

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ENROLLMENT FORM #IMM-K-12
8/2016

Immunization and Health Assessment Requirements

HEALTH ASSESSMENTS:

All students entering the NC public school system for the first time must provide proof of health assessment completed within the past 12 months, on or before the first day of attendance.

- **Pre-K students** (see program guidelines for appropriate health assessment form)
- **Kindergarten through 12th grade students enrolling for the first time in a North Carolina public school** (NC Health Assessment Transmittal Form)

IMMUNIZATIONS:

NC immunization law requires that each student provide a complete immunization record prior to attending school. Required vaccines for school attendance are listed below:

Pre-K students:

- The student should have received the required immunizations for their age.

Kindergarten through 12th grade students must provide proof of completing the vaccine series listed below:

- DTP/DtaP (Diphtheria, Tetanus and Pertussis)
- Polio (IPV)
- HIB (Haemophilus Influenza Type b)
- Hepatitis B
- MMR (Measles, Mumps and Rubella)
- Varicella

7th Grade students must provide proof of receiving the following boosters:

- Tdap (Tetanus/Diphtheria/Pertussis)
- MCV (Meningococcal Conjugate Vaccine)

Additional immunization information and the NC Health Assessment Transmittal form may be obtained on the RSSS district website at http://www.rss.k12.nc.us/content/school-health-immunizations. If you have specific questions regarding immunizations or health assessment, contact your child's health care provider or your local health department. **Parents have 30 calendar days to provide the school with a valid immunization record and health assessment, if applicable. After 30 days, the student must be excluded from the school setting.**

CHRONIC HEALTH CONDITIONS:

Contact the School Nurse if your child has any health condition(s) that may require emergency assistance during the school day. Emergency Plans may include, but are not limited to:

- Diabetic Action Plan (for both Type 1 and Type 2 diabetics)
- Asthma Action Plan
- Seizure Action Plan
- Severe Allergy Action Plan