CUMBERLAND COUNTY SCHOOLS
PHYSICIAN'S SCHOOL MEDICATION FORM Rev. 04/2025

TO BE COMPLETED BY MEDICAL PROVIDER

Student's Name: _____ Date of Birth: _____

Name of School: _____ Grade: _____

The above named person is a patient currently under my medical care. Due to a medical condition the medication listed below must be (given/taken/injected) during regular school hours according to the following protocol:

Medication: _____ Dose: _____ Route: _____

Dose must be exact; ranges will not be accepted.

☐ Routine/Daily Medications: exact time to be given _____ a.m. _____ p.m.

☐ As needed (p.r.n.) medication for: _____ give every _____ hour(s).

Directions for administering medication: _____

_____

Please indicate any special storage requirements such as room temperature, refrigeration, etc. _____

_____

Physician's Signature: _____ Date: _____ **MD Stamp Below**

Physician's Printed Name: _____

Office Phone: _____ FAX: _____

Office Address: _____

City, State, ZIP: _____

This order will expire one year from the date the physician signed.

TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN

I understand that:

- prescription medications may be administered at school and must be in a pharmacy-labeled prescription bottle that matches the CCS Physician's School Medication Form. Medication dosage, time and intervals, must be exact.
- the school nurse is available one day a week.
- non-medical personnel administer medications daily.
- prior to school administration, the parent/guardian is required to sign the check-in/check-out log for medication.
- students are not permitted to transport medication to or from school.
- medication may only be administered as ordered on the approved CCS medication forms.
- if medication is not available at the school, 911 will be called for emergencies.
- the parent/guardian is responsible for notifying coaches or supervising staff of before and/or after-school activities of the child's health status and/or the need for medication.
- I may contact the Primary Medication Clerk or school nurse if assistance is needed to ensure medication meets CCS Protocol for Medication Administration.
- **medication not picked up within two weeks of the last day of school will be discarded.**

RELEASE OF LIABILITY FORM *(to be completed by parent/guardian)*

I, _____ (Parent/Guardian Name), the parent and/or legal guardian of _____ (Student's Name), enrolled at _____ (School Name), understanding the importance of administering medication as prescribed by my child's physician, hereby agree to release and hold harmless designated school personnel and the Cumberland County Department of Public Health personnel from any liability related to the administration of medication, including injections, to my child.

I acknowledge that I have discussed this matter with my physician and/or legal counsel, and fully understand the potential ramifications of this consent. I grant permission for the medical provider to disclose necessary health or medical information regarding the prescribed medication to the school personnel involved in its administration.

I understand that I have the right to revoke this consent at any time, except where actions have already been taken based on this consent. This consent remains valid for one year or until I revoke it in writing, whichever occurs first.

Parent/Legal Guardian's Signature: _____ Date: _____

Principal's Signature: _____ Date: _____

FOR OFFICE USE ONLY: This order will expire one year from the date the physician signed. This form will expire on _____

DISPOSITION OF MEDICATION: Date medication was picked up _____ or date medication was discarded _____

by Staff Name: Staff Signature: Witness: