CUMBERLAND COUNTY SCHOOLS
SHORT-TERM MEDICATION FORM

Rev. 05/2018

May Not Exceed 14 Calendar Days

Student's Name: ____ Date of Birth:__________

Name of School: ____ Grade:__________

Parent/Guardian: ____ Phone:______________

Prescribing Physician: __________________________________ Physician's Phone:______________

Reason for medication: ____

Date and time this medication was first administered to the student by the parent/guardian. ____________

List allergies:____

Name of prescription medication: ________________________ Dose:______ Route:______________

Medication exact time to be given _____a.m. _____p.m. **Dose must be exact; ranges will not be accepted.**

Directions for administering medication:____

Short-term medication may not exceed 14 calendar days. Start date for medication: ________________

I understand that:

- the school nurse is available one day a week.
- non-medical personnel administer medications daily.
- prior to school administration, the parent/guardian is required sign the check-in/check-out log for medication.
- students are not permitted to transport medication to or from school.
- 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 fourteen (14) calendar days of the expiration of this form will be discarded.

RELEASE OF LIABILITY FORM

I,________________________________the parent/legal guardian of ______________________________ enrolled at __________________________school realizing the importance of administering medication to my child as prescribed by the child's physician, do hereby agree to relieve designated school personnel, the Cumberland County Schools, and the Cumberland County Board of Education of and from any liability from any potential ill effects as a result of their injecting or giving my child medication prescribed by the child's physician. I have discussed this with my physician and/or legal counsel (lawyer) and realize its ramifications and thoroughly understand the meanings of these statements. I consent for the medical provider to disclose health or medical information regarding medication prescribed. I understand that I may revoke this consent at any time, except to the extent action has been taken in reliance on it. This consent is valid until I revoke it in writing or for the term fourteen (14) calendar days.

Parent/Legal Guardian's Signature:__________________________________ Date:________________

Principal's Signature: ____ Date:________________

FOR OFFICE USE ONLY: This form will expire 14 days from the date the parent 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: