ECPPS
ELIZABETH CITY- PASQUOTANK PUBLIC SCHOOLS
PREPARING GLOBALLY COMPETITIVE CITIZENS

# ECPPS Authorization for School Personnel to Administer Medication During School Hours

The following section is to be completed by the **PARENT:**

School:_____ Teacher:_____

Student:_____ Sex:_____ Date of Birth:_____

Physician's Name:_____ Physician Phone Number:_____

I hereby give my permission for my child (named above) to receive medication during school hours.

I understand that the school undertakes no responsibility for the administration of the medication.

This medication has been prescribed by a licensed physician.

I hereby release the Elizabeth City-Pasquotank School Board and their agents and employees from any liability that may result from my child taking the prescribed medication.

_____ _____ _____
Parent/Guardian Home Phone Emergency Phone

The following is to be completed by the PHYSICIAN:

**Diagnosis for which medication is given:**_____

**Name of Medicine:**_____

**Form:**_____

**Dose:**_____

**If medicine is to be given DAILY, at what time?**_____

**If medicine is to be given "WHEN NEEDED"**

**describe indications:**_____

**How soon can it be repeated?**_____

**Is child authorized to medicate him/herself?**_____

**List significant side effects:**_____

**Length of time this treatment is recommended:**_____

**Other information:**

Physician's Signature _____ Date _____