Medication Authorization Form 2018-2019

Parents should complete this form and return

Please Note: In accordance with North Carolina General Statute 115C-375.1 ALL MEDICATIONS REQUIRE A PARENT AND PHYSICIAN'S SIGNATURE.

Student Name: Last_________________________First_______________________Middle__________

Grade ______________

Date of Birth______________Address________________________

Parent/Guardian Name_________________________________Telephone______________Cell __________

TO BE COMPLETED BY PHYSICIAN

Authorization for medications to be administered during the academic day and all school sponsored events

Tylenol/generic, Dose______________	Yes	No	Antacids (Tums) Dose__________	Yes	No
Motrin/generic, Dose______________	Yes	No	Topical antibiotic ointment (i.e. Neosporin)	Yes	No
Benadryl (for allergic reactions), Dose______	Yes	No	Topical anti-itch analgesic (i.e. hydrocortisone)	Yes	No

SECTION 1: **Please circle the following OTC Medication(s) that the student may be given during the school year.**

SECTION 2: **Please complete the following for any prescription medication OR additional OTC (i.e. Allergy Medication, etc.) to be given during the school year.**

The above name student is under my care for (diagnosis):

Medication(s) to be administered during school hours:

Dosage/Route/Frequency:________________________ Administration: Begins______________ Ends _________

Possible side effects:

Signature of Physician, CRNP or PA:_______________________________ Phone #_______

Printed name of Physician, CRNP or PA: _______________________________ Date:

The above medication order is valid 8/14/18 - 5/22/19.

An **Action Plan** is required for students with a history of asthma, diabetes, allergic reactions, seizures, or other chronic medical conditions requiring treatment. This form must be completed by the physician.

PLEASE SEE REVERSE SIDE OF THIS FORM FOR FURTHER INFORMATION

TO BE COMPLETED BY THE PARENT

I request the medication listed above to be given to this student during school hours and all school-sponsored events. I understand that only I, or appointed school personnel, may administer this medication during school hours or school-sponsored events to this student. I acknowledge that the school shall incur no liability as a result of any conditions from the medication; I shall hold harmless the school, its employees, or agents against any claims arising from the administration of medication given to this student.

Signature of Parent:____ Date:

Parents please initial any special directives added in the space below regarding the student medication:

_______I will pick up any unused medication on the last day of school _______Please discard any unused medication on the last day of school

ALL MEDICATION WILL BE DISCARDED IF NOT PICKED UP BY MAY 22, 2019