PHYSICIAN'S AUTHORIZATION OF MEDICATION FOR A STUDENT AT SCHOOL

SCHOOL: _____ **TODAY'S DATE:** _____

STUDENT: _____ **DATE OF BIRTH:** _____

In order to keep this child in optimum health and to help maintain maximum school performance, it is necessary that medication be given during school hours.

MEDICATION: _____ **Color (if applicable)** _____
(include trade name and prescription number)

Medication to be Given as Circled: TABLET OINTMENT CAPSULE INHALATION LIQUID OTHER (please specify):

DOSAGE (Amount to be given): _____

TIME/FREQUENCY: _____ AM _____ PM or _____ AS NEEDED

RELATIONSHIP TO MEALS: _____

SIDE EFFECTS: _____

☐ **Student is responsible and knowledgeable and may carry medication on his/her person**

The child's parents are aware of this request and are in full agreement that this medication will be supplied as needed. Should the child manifest any of the following symptoms caused by the medication, please contact the parents or school nurse.

Contraindications for Administration: _____

Physician's Stamp	_____ *Telephone*	_____ *Physician's Signature*

PARENTAL PERMISSION

I hereby give permission for my child (named above) to receive this medication during school hours. I understand that the school undertakes no responsibility for administration of the medication. This medication has been prescribed by a licensed physician. I hereby release the Stanly County School Board and its employees from any and all liability which may result from my child taking the prescribed medication.

_____ *Date*	_____ *Telephone*	_____ *Parent/Guardian's Signature*

FOR SCHOOL USE ONLY

Name, Title of Person to Administer Drug: _____

Approved By:

_____ *Principal* _____ *Date*

Reviewed By:

_____ *School Nurse* _____ *Date*

- **School nurse will retain copy for files**
- **School will file a copy after nurse signs**

****MEDICATION WILL NOT BE ADMINISTERED ON DELAYED DAYS/ EARLY RELEASE DAYS IF OUTSIDE OF SCHEDULED MEDICATION WINDOW.**