Carolina Christian School

"He will teach us His ways so that we may walk in His paths." Micah 4:2b

MEDICATION AUTHORIZATION 2024-25 School Year

**Attention Parents: This form is for medications to be given to your child at school. NC State Law states that for a Nurse or designated Staff Member to administer medications, both prescription AND over the counter (OTC), this form MUST be signed by a Physician and Parent. Parents must provide the medication in its original container. All unused medications will be returned to you at the end of the school year.*

Student's Name_____**Grade**_____

Drug Allergies_____

Date of Birth_____ **Weight**_____

Parent Complete

I, _____(do___) (do not___)authorize my child's health care provider and the school nurse to discuss my child's health concerns and/or exchange information pertaining to school health forms. *This authorization will be in place until or unless you withdraw it. You may withdraw your authorization at any time by contacting your child's school.* **I authorize the medication(s) checked below by the care provider to be given as ordered to my child.**

Signature of parent/legal guardian_____Date_____

Physician/Provider Complete

The over the counter medication dosage will be administered according to the manufacturer's recommendations on the label unless otherwise indicated by a physician. Generic substitutions may be used for non-prescription medications listed. This form will also be the authorized form used for off campus activities, including overnight trips.

Non-prescription medication stocked in office include the following (**please check** those that are to be given as needed):

- ☐ Tylenol (Acetaminophen) ☐ Advil (Ibuprofen) ☐ Benadryl / Allergy medications
- ☐ Cough drops / Throat Lozenges ☐ Antacids ☐ Sudafed PE / Decongestant
- ☐ Neosporin/Hydrocortisone lotion/Benadryl spray and lotion/topical sting relief

Please list any **other medications** which would need administering during school or school related activities, whether to be administered by school personnel or self (student). Students requiring emergency PRN medications, please complete Medical Action Plan. List additional medications on page 2.

Name of medication_____Dosage_____

Route_____Hours to be given_____

Order in effect until (date):_____

Student may self administer the medication ordered: yes_____ no_____

Physician/Nurse Practitioner/PA
Signature_____Date_____

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Additional Medication to be given during school or school related activities.

Name of medication_____Dosage_____

Route_____Hours to be given_____

Order in effect until (date):_____

Student may self administer the medication ordered: yes_____ no_____

Name of medication_____Dosage_____

Route_____Hours to be given_____

Order in effect until (date):_____

Student may self administer the medication ordered: yes_____ no_____

Name of medication_____Dosage_____

Route_____Hours to be given_____

Order in effect until (date):_____

Student may self administer the medication ordered: yes_____ no_____

Physician/Nurse Practitioner/PA

Signature_____Date_____