



Carolina Christian School

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

MEDICATION AUTHORIZATION

*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. You 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 _____

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| Parent Complete | <p>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. <i>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.</i></p> <p>Signature of parent/legal guardian _____ Date _____</p> |
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| Physician/Provider Complete | <p>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.</p> <p>Non-prescription medication stocked in office include the following (please check those that are to be given as needed):</p> <p><input type="checkbox"/> Tylenol (Acetaminophen) <input type="checkbox"/> Advil (Ibuprofen) <input type="checkbox"/> Benadryl / Allergy medications</p> <p><input type="checkbox"/> Cough drops / Throat Lozenges <input type="checkbox"/> Antacids <input type="checkbox"/> Sudafed PE / Decongestant</p> <p><input type="checkbox"/> Neosporin/Hydrocortisone lotion/Benadryl spray and lotion/topical sting relief</p> <p>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.</p> <p>Name of medication _____ Dosage _____</p> <p>Route _____ Hours to be given _____</p> <p>Order in effect until (date): _____</p> <p>Student may self administer the medication ordered: yes _____ no _____</p> <p>Physician/Nurse Practitioner/PA Signature _____ Date _____</p> |
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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** _____