# 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): _____

HOW OFTEN OR AT WHAT TIME: _____

RELATIONSHIP TO MEALS: _____

SIDE EFFECTS: _____

*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 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. / 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:**

_____ _____
*Medical/Social Worker* *Date*