GUILFORD COUNTY SCHOOLS
AUTHORIZATION OF MEDICATION FOR A STUDENT AT SCHOOL

Check one: ______ Prescription ______ Non-Prescription

School: ________________________________ School Address: ________________________________

Name of Student: ________________________________ Date of Birth: ____________________________

IN ORDER TO KEEP THIS STUDENT IN OPTIMUM HEALTH AND TO HELP MAINTAIN MAXIMUM SCHOOL PERFORMANCE, IT IS NECESSARY THAT MEDICATION BE GIVEN DURING SCHOOL HOURS.

Prescribing Health Care Clinician: ________________________________ Phone: ____________________

Medication: ____________________________ Diagnosis: ________________________________

Dosage and Frequency (amount to be given and time): ____

Expected Dates for Administration: ____

Possible Adverse Reactions That Should Be Reported to Health Care Clinician: ____________________

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☐ Check here if serious reaction can occur if medication not given exactly as prescribed.

☐ Check here if serious reaction can occur even when medication is administered properly.

☐ Student has been instructed, understands and has demonstrated the skill to self administer his/her emergency medication.

Special handling instructions: ____

NOTE: The health care clinician may use another format (computer printout, letter, etc.) to authorize administration of the medication. However, <u>all</u> information requested above must be provided.

________________________________ ____________________ ______________
Signature of Health Care Clinician Date Phone

PARENT'S PERMISSION
I hereby give my permission for my child (named above) to receive medication during school hours. This medication has been prescribed by a licensed physician or other health care clinician. I hereby release the Board of Education and their agents and employees from any and all liability that may result from my child taking the prescribed medication.

________________________________ ____________________ ______________
Signature of Parent or Guardian Date Phone

(SCHOOL USE ONLY)
Name and title of person(s) designated by principal to administer medication:

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☐ Student has demonstrated to the school nurse the skill to self administer his/her emergency medication.

Content reviewed by: ____
Signature of School Health Nurse Date

Withdrawal of authorization was made in writing (attach note from parents) ____________________
Date