Every child. Every day.
Mooresville
GRADED SCHOOL DISTRICT

MEDICATION AUTHORIZATION FORM

School Name _____ Telephone_____ Fax_____

Student's Name _____ Date of Birth _____

In order to help protect your child's health, your consent and written authorization from a licensed health care provider are required when it is necessary for your child to receive prescription and non-prescription medicines in the Mooresville Graded School District. Medications cannot be given to your child at school until this authorization has been received. A separate form is required for each medicine. New authorization forms are required every year at the beginning of school, whenever the dose or directions change, or when a new medicine is prescribed. It is your responsibility to provide all medicines to be given at school. Each medicine must be in an appropriately labeled original container from the pharmacy or health care provider's office. Most pharmacies will provide an extra container for school use upon request. Administration of non-prescription medicines at school is discouraged.

Parent or Guardian's Permission: I give permission for my child to receive this medicine during school hours. I understand that it is my responsibility to purchase and supply this medicine. On behalf of my child I absolve the Mooresville Graded School District Board of Education and their agents and employees from any and all liability whatsoever that may result from my child taking this medicine at school.

_____ _____

Signature of parent or guardian Date Daytime Contact numbers (home, cell etc.)

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FOR HEALTH PROFESSIONAL USE ONLY: PLEASE WRITE LEGIBLY

Medication Prescribed _____ Strength /Dose_____

Specific Directions (include exact amount to give, at what time and/or how often, relationship to meals, specific indications if prn):

_____

Expected side effects or adverse reactions: __ please reference standards __ specify:_____

Other instructions_____

____ (Check if applicable) **THIS MEDICATION IS TO BE USED FOR EMERGENCIES ONLY.**

For Emergency Medications only (circle one):

_____ (Check if applicable) Please allow this student to self-administer this medication.

_____ (Check if applicable) This student should carry this medication with him/her at all times.

It is necessary for this student to receive this medication during school hours in order to maintain or improve health and to benefit from school attendance. Please notify the principal and/or school nurse and parents/guardians if there are any problems.

_____

Signature of Health Provider Date Telephone Fax