CHARLOTTE CHRISTIAN SCHOOL
veritas tota | homini toti

MEDICATION AUTHORIZATION FORM | 2023-24

Health Room Fax #: (704) 368-1078

North Carolina law requires school nurses to have a **physician's order** on file in order to administer all medications to your child including over-the-counter and prescribed. If a student needs to receive over-the-counter (OTC) and/or prescription medication during school hours or while attending an overnight school trip, this form must be completed and **signed by the student's parent and physician annually.**

ALL MEDICATIONS ARE GIVEN PER MANUFACTURER'S RECOMMENDED DOSE.

TO BE COMPLETED BY PARENT

STUDENT

First: _____

Last: _____

DOB: _____ **Grade:** _____

Allergies: _____

_____

PARENT

Parent's Names: _____

Father Cell: _____

Mother Cell: _____

Emergency Contact Name: _____
(other than parent)

Emergency Contact Number: _____

TO BE COMPLETED BY PHYSICIAN

SECTION 1: OVER-THE-COUNTER MEDICATIONS - Please check which medications this student can take as needed.

___ Yes ___ No Tylenol/generic

___ Yes ___ No Motrin/generic

___ Yes ___ No Benadryl (for allergic reactions)

___ Yes ___ No Antacids (Tums)

___ Yes ___ No Throat lozenges (middle & upper school only)

___ Yes ___ No Calagel (topical anti-itch analgesic)

SECTION 2: ADDITIONAL MEDICATIONS - Please complete the following for any prescription medication or additional OTC (i.e. seasonal allergy medication, supplements, etc.) to be given during the school year or while attending an overnight school trip. Any medications not listed above will need to be provided to the Health Room in the original packaging or labeled prescription bottle.

DRUG	ROUTE	DOSAGE	TIMES TO BE GIVEN	SIDE EFFECTS	COMMENTS

→ PHYSICIAN SIGNATURE: _____ DATE: _____

PHYSICIAN NAME PRINTED: _____ PHONE: _____

TO BE COMPLETED BY PARENT/GUARDIAN

MEDICATION DELIVERED TO HEALTH ROOM:

- Medication must be in the original container.

I/we hereby request the medication listed above be given to this student during school hours and all school sponsored events. I/we understand that only I/we, or the school nurse or appointed school personnel, may administer this medication during school hours or school sponsored events to this student. I/we acknowledge that the school shall incur no liability as a result of any conditions from the medication. I/we shall hold harmless the school, its employees or agents against any claims arising from the administration of medication given to this student.

Authorization to Treat Statement: I/we the parent(s) or legal guardian(s) of the above-named minor do hereby appoint a Charlotte Christian School representative to act in my/our behalf in authorizing unexpected medical, dental, surgical treatment and/or hospitalization for the above-named minor during our absence for the current school year. The student health record and this document shall be presented to the physician, dentist and/or hospital representative at such time as an unexpected health issue occurs.

→ PARENT SIGNATURE: _____ DATE: _____

Please make a copy of your student's forms to keep for your records.

THE ABOVE MEDICATION ORDER IS VALID FOR ONE YEAR FROM THE DATE SIGNED BY THE PHYSICIAN.