



## Medication Authorization for School Year \_\_\_\_\_

**\*\*This form must be completed in full for your student to receive any medication\*\***

Per the Diocese of Charlotte Catholic Schools policy as well as NC state law, NO medication (non-prescription or prescription) will be given to a student without authorization from a physician.

Student: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

D.O.B: \_\_\_\_\_ Weight: \_\_\_\_\_ Allergies: \_\_\_\_\_

**Prescription Medication:** \_\_\_\_\_ **Dose:** \_\_\_\_\_ **Route:** \_\_\_\_\_

**Time to be Given:** \_\_\_\_\_ **Reason for Medication:** \_\_\_\_\_

**Side effects:** \_\_\_\_\_

**Prescription Medication:** \_\_\_\_\_ **Dose:** \_\_\_\_\_ **Route:** \_\_\_\_\_

**Time to be Given:** \_\_\_\_\_ **Reason for Medication:** \_\_\_\_\_

**Side effects:** \_\_\_\_\_

If your student requires emergency medication (epi-pen, rescue inhaler, insulin) please also complete an **ACTION PLAN**.

**ONLY students in grades 6-12 are permitted to self-carry emergency medication.** A student cannot self-carry non-emergency medication.

**Student is responsible and capable to carry emergency medications/self-medicate: Yes \_\_\_\_\_ No \_\_\_\_\_**

Please **CHECK** what non-prescription (over the counter) medication your student **CAN** take if requested. Medication will be given according to manufacturer's directions unless otherwise indicated.

\_\_\_\_ Acetaminophen (Ex. Tylenol)

\_\_\_\_ Hydrocortisone Cream (topical)

\_\_\_\_ Ibuprofen (Ex. Advil, Motrin)

\_\_\_\_ Throat Lozenges/Cough Drops

\_\_\_\_ Antacid (Ex. Tums)

\_\_\_\_ Benzocaine (for insect stings)

\_\_\_\_ Diphenhydramine Oral (Ex. Benadryl liquid/capsule)

\_\_\_\_ Polysporin ointment (Ex. Neosporin)

\_\_\_\_ Diphenhydramine Topical (Ex. Benadryl cream/gel)

\_\_\_\_ Dramamine (for motion sickness/parent to supply)

\_\_\_\_ Cetirizine (Zyrtec) for seasonal allergy relief

\_\_\_\_ Eye Drops (parent to supply)



**Medical Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name of Medical Provider:** \_\_\_\_\_ **Phone#:** \_\_\_\_\_

I am requesting the medication(s) above to be administered as indicated to my student while on school property and during school sponsored events, including field trips. I understand that only the school nurse and/or school personnel may give my student medication. I also give permission for the school nurse and provider listed above to exchange health related information regarding my student's health status and medication. On behalf of my student (child), I acknowledge that the school shall incur no liability as a result of any conditions from this medicine and I shall hold harmless the school, its employees, or agents against any claims arising from the administration of medication given to this student.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

This form is valid for 1 full school year **ONLY**.