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 PERFORMANCE, IT IS NECESSARY TH		
Prescribing Health Care Clinician:	Ph	one:
Medication:	Diagnosis:	
Dosage and Frequency (amount to be give	en and time):	
Expected Dates for Administration:		
Possible Adverse Reactions That Should	Be Reported to Health Care Clinician:	
Check here if serious reaction car medication not given exactly as process.	I	here if serious reaction can occur hen medication is administered y.
Student has been instructed, under medication.	erstands and has demonstrated the ski	Il to self administer his/her emergency
Special handling instructions:		
NOTE: The health care clinician may use medication. However, <u>all</u> information requ		er, etc.) to authorize administration of th
Signature of Health Care Clinician	Date	Phone
PARENT'S PERMISSION I hereby give my permission for my child (been prescribed by a licensed physician o agents and employees from any and all lia	or other health care clinician. I hereby r	uring school hours. This medication has elease the Board of Education and their
Signature of Parent or Guardian	Date	Phone
(SCHOOL USE ONLY) Name and title of person(s) designated by	principal to administer medication:	
Student has demonstrated to the	school nurse the skill to self administer	his/her emergency medication.
Content reviewed by:	Signature of School Health Nurs	se Date
Withdrawal of authorization was made in v	writing (attach note from parents)	 Date