DIOCESE OF CHARLOTTE
CATHOLIC SCHOOLS

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)

____ Ibuprofen (Ex. Advil, Motrin)

____ Antacid (Ex. Tums)

____ Diphenhydramine Oral (Ex. Benadryl liquid/capsule)

____ Diphenhydramine Topical (Ex. Benadryl cream/gel)

____ Cetirizine (Zyrtec) for seasonal allergy relief

____ Hydrocortisone Cream (topical)

____ Throat Lozenges/Cough Drops

____ Benzocaine (for insect stings)

____ Polysporin ointment (Ex. Neosporin)

____ Dramamine (for motion sickness/parent to supply)

____ 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.