CAROLINA DAY SCHOOL

Medication Authorization Form

Must be signed by licensed health care provider and parent

(In accordance with North Carolina General Statute 115C-375.1)

Student's Name: _____ Circle M/F Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Parent/Guardian _____

Name Home Phone Cell Phone

Section 1: Please complete the following for any prescription medication or over-the-counter medication to be given during the school year.

Medication #1: _____ Dosage and Route: _____

Time(s): _____ a.m. _____ p.m. PRN _____ begins: _____ ends: _____

Significant Information (including side effects, toxic reactions, and omission reactions): _____

_____

Contraindications for Administrations: _____

Medication #2: _____ Dosage and Route: _____

Time(s): _____ a.m. _____ p.m. PRN _____ begins: _____ ends: _____

Significant Information (including side effects, toxic reactions, and omission reactions): _____

_____

Contraindications for Administrations: _____

Medication #3: _____ Dosage and Route: _____

Time(s): _____ a.m. _____ p.m. PRN _____ begins: _____ ends: _____

Significant Information (including side effects, toxic reactions, and omission reactions): _____

_____

Contraindications for Administrations: _____

Medication #4: _____ Dosage and Route: _____

Time(s): _____ a.m. _____ p.m. PRN _____ begins: _____ ends: _____

Significant Information (including side effects, toxic reactions, and omission reactions): _____

_____

Contraindications for Administrations: _____

Medication #5: _____ Dosage and Route: _____

Time(s): _____ a.m. _____ p.m. PRN _____ begins: _____ ends: _____

Significant Information (including side effects, toxic reactions, and omission reactions): _____

_____

Contraindications for Administrations: _____

Medication #6: _____ Dosage and Route: _____

Time(s): _____ a.m. _____ p.m. PRN _____ begins: _____ ends: _____

Significant Information (including side effects, toxic reactions, and omission reactions): _____

_____

Contraindications for Administrations: _____

Section 2: The above named student has demonstrated ability, understands the use of, and may carry and self-administer *asthma medication, diabetes medication, or medicine for anaphylactic reactions*.

Medication(s): _____

Signature of physician, CRNP or PA: _____ **Phone:** _____

Printed name of physician, CRNP or PA: _____ **Date:** _____

The above medication order is valid for 12 months from date of signing.

TO BE COMPLETED BY PARENT/GUARDIAN

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

Signature of Parent/Guardian: _____ **Date:** _____