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 OPTIMUM HEALTH AND TO HELP MAINTAIN MAXIMUM SCHOOL PERFORMANCE, IT IS NECESSARY THAT MEDICATION BE GIVEN DURING SCHOOL HOURS.

Prescribing Health Care Clinician:_____Phone: _____

Medication: Diagnosis: _____

Dosage and Frequency (amount to be given and time):_____

Expected Dates for Administration: _____

Possible Adverse Reactions That Should Be Reported to Health Care Clinician: _____

_____

☐ Check here if serious reaction can occur if medication not given exactly as prescribed.

☐ Check here if serious reaction can occur even when medication is administered properly.

☐ Student has been instructed, understands and has demonstrated the skill to self administer his/her emergency medication.

Special handling instructions:_____

NOTE: The health care clinician may use another format (computer printout, letter, etc.) to authorize administration of the medication. However, all information requested above must be provided.

_____ _____ _____
Signature of Health Care Clinician Date Phone

PARENT'S PERMISSION
I hereby give my permission for my child (named above) to receive medication during school hours. This medication has been prescribed by a licensed physician or other health care clinician. I hereby release the Board of Education and their agents and employees from any and all liability that may result from my child taking the prescribed medication.

_____ _____ _____
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 Nurse Date

Withdrawal of authorization was made in writing (attach note from parents) _____
Date