Charlotte-Mecklenburg Schools

MEDICATION AUTHORIZATION FOR CMS STUDENTS

School name: _____ Telephone: _____ Fax: _____

To the Parent/Guardian of: _____ Birth date: _____

In order to help protect your child's health, your consent and written authorization from a licensed healthcare provider are required when it is necessary for your child to receive either prescription or non-prescription medications in the Charlotte-Mecklenburg Schools. No medications will be given to your child at school until this authorization has been received. A separate form is required for each medication. New authorization forms are required every year at the beginning of school, whenever the dose or directions change, or when a new medication is prescribed. It is your responsibility to provide all medications to be given at school. Each medication must be in an appropriately labeled original container from the pharmacy or healthcare provider's office. Most pharmacies will provide an extra container for school use upon request. Administration of non-prescription medications at school is discouraged.

Parent/Guardian's Permission: I give permission for my child to receive the medication described below during school hours. I understand that it is my responsibility to purchase and supply this medication. On behalf of my child, I absolve the Charlotte-Mecklenburg Board of Education and their agents and employees from any and all liability whatsoever that may result from my child taking this medication at school.

Parent/Guardian signature: _____ Date: _____

Contact numbers: _____

(pager or mobile, work, home telephone #s)

FOR LICENSED HEALTHCARE PROVIDER USE ONLY: (Please write legibly using lay terms.)

Medication prescribed: _____ Strength/dose: _____

Specific Directions:
[include exact amount to give, at what time and/or how often, relationship to meals, specific indications, e.g. if prn (as needed)]

Purpose of medication: _____

Relationship to meals, if applicable: _____

How often and at what time (hour): _____

Specify side effects or adverse reactions: _____

Other instructions (including emergency situations): _____

Please check all appropriate items. If either of the first two items is checked, page 7 of this booklet (Authorization For Self-Medication By CMS Students) must be completed.

- ❑ Please allow this student to self-administer this medication while at school during school hours **(page 7 of this booklet)**
- ❑ This student should carry the medication with him/her at all times during the school day, while at school-sponsored events, or while in transit to or from school or school-sponsored activities **(page 7 of this booklet)**
- ❑ This medication is to be used for emergencies only

It is necessary for this student to receive this medication during school hours in order to maintain or improve health and to benefit from school attendance. Please notify the principal and/or school nurse and parents/guardians if there are any problems.

Healthcare provider signature: _____ Provider's last name (Print): _____

Practice name or address: _____

Telephone: _____ Fax: _____ Date: _____

FOR SCHOOL USE ONLY:

Date Received By: _____ School Health Nurse Review: _____

Please complete form and return to your student's school.