MEDICATION AUTHORIZATION FORM

Student's Name (Please print) | **Grade** | **For School Use Only**
Date Received/Receiver's Signature:

Teacher's Name | **Student's Date of Birth**
Medication Received? ❒ yes ❒ no
Date Approved

Entered in PowerSchool ❒ yes ❒ no

Written parent/guardian consent and an order from a healthcare provider licensed in North Carolina are required for administering prescription and over-the-counter medications at school. When possible, medications should be taken before or after school. Administration of non-prescription medications is discouraged.

SECTION 1: LICENSED HEALTHCARE PROVIDER AUTHORIZATION

- ACS action plan for diabetes is to be used instead of this form.
- When using this form, complete a separate form for each medication; write legibly; use lay terms.
- All medication shall be kept in the school health room to be administered by the designated staff person.
- Rescue Inhalers and Epinephrine Auto Injectors are encouraged to be kept in the classroom in close proximity to the student.
- Please attach additional documentation from your physician for Epinephrine and Rescue Inhaler use

Medication: (Generic/Brand)	Controlled Substance? ❒ yes ❒ no
Dose/Dosing Instructions:	Route:
Administration Time: Relationship to meals: ❒ Not applicable ❒ With meals ❒ With snacks ❒ Other:	❒ PRN (specify time interval):
Purpose:	Check here if this medication is to be used for emergencies only. ❒
Side Effects/Adverse Reactions:	
Anticipated length of treatment: ❒ School Year ❒ ___ Months ❒ ___ Weeks ❒ ___ Days	Other Instructions (including emergency situations):

In my professional opinion, it is medically necessary for this student to receive this medication during school hours.

Signature of Healthcare Provider:_____ **Date:** _____

Stamp, Print or Type Healthcare Provider's Name & Address	**Office Phone**
	Office Fax

SECTION 2: PARENT / LEGAL GUARDIAN CONSENT

- I understand: No medication will be given at school until this authorization has been approved. New authorization forms are required at the beginning of every school year, when the dose or directions change, and when a new medication is prescribed. It is my responsibility to supply the medication. Each medication must be in the original labeled container from the pharmacy or healthcare provider's office. Some pharmacies will provide an extra container for school use. Information about this medication and my child's health may be shared with school staff or agents of the school to help assure my child's safety and success at school. Medications are given by designated ACS staff.
- I give permission for my child to receive the medication described above during school hours. I give permission for the healthcare provider, pharmacist and their staff to provide information to the school about this medication and my child's health.
- On behalf of my child, I release the Alamance Community School Board, their agents and employees from any and all liability whatsoever that may result from my child taking this medication at school.

Parent/Legal Guardian Signature:	**Date:**	**Phone Numbers (mobile, work, home):**
Parent/Legal Guardian (Print Name):		

PRINCIPAL / DESIGNEE

I have reviewed this request and approve this student for self-administering this medication.

Principal/Designee Signature:	Date:
Principal/Designee (Print Name):	