MEDICATION AUTHORIZATION FOR CMS STUDENTS

School Name: _JM Robinson Middle School___ Telephone: _(980)343-6944__ Fax: __(980)343-6947___

To the parent or guardian of: ______________________________ Birthdate: ______________________

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 medication 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.

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Parent or 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.

____ ____

Signature of parent or guardian Date Contact numbers (pager or mobile, work, home telephone #s)

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FOR LICENSED HEALTHCARE PROFESSIONAL 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 2 of this form *must* be completed.

☐ Please allow this student to self-administer this medication while at school during school hours. (must complete page 2 of this form.)

☐ 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. (must complete page 2 of this form.)

☐ 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.

____ ______________________ ______________________

Signature of health care provider Date Telephone Fax

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Please print provider's last name Practice name or address

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FOR SCHOOL USE ONLY:

Date Received/By: ________________________________School Health Nurse Review: ______________________