CHARLOTTE CHRISTIAN SCHOOL - 2020-21 MEDICATION AUTHORIZATION FORM

Fax: (704) 366-5678

North Carolina law requires school nurses to have a physician's order on file in order to administer **all** medications to your child including over-the-counter and prescribed. If it is necessary for a student to receive over-the-counter (OTC) and/or prescription medication during school hours or while attending an overnight school trip, this form must be completed and **signed by the student's parent and physician annually.** Please anticipate OTC medications that may be given seasonally or annually (i.e. OTC vitamins, allergy medication, melatonin, magnesium supplements, etc.) and have your doctor write them in the space provided on this form. **Absolutely no medications will be administered by school personnel or be self-administered without written authorization.** ALL MEDICATIONS ARE GIVEN PER MANUFACTURER'S RECOMMENDED DOSE. ANY STUDENT WHO REQUIRES EMERGENCY MEDICATION (I.E...), "MUST ALSO SUBMIT AN ACTION PLAN".

STUDENT

FIRST: _____

LAST: _____

DOB: _____

GRADE: _____

ALLERGIES: _____

PARENT

PARENTS' NAMES: _____

FATHER CELL: _____

MOTHER CELL: _____

EMERGENCY CONTACT NAME (other than parent): _____

EMERGENCY CONTACT NUMBER: _____

TO BE COMPLETED BY PHYSICIAN

SECTION 1: OVER-THE-COUNTER MEDICATIONS - Please check which medications this student can take as needed.

__ Yes __ No Tylenol/generic
__ Yes __ No Motrin/generic
__ Yes __ No Benadryl (for allergic reactions)
__ Yes __ No Antacids (Tums)
__ Yes __ No Throat Lozenges (middle & high school only)
__ Yes __ No Calagel (topical anti-itch analgesic)

SECTION 2: PRESCRIPTION MEDICATIONS - Please complete the following for any prescription medication or additional OTC (i.e. seasonally allergy medication, vitamins, supplements, etc.) to be given during the school year or while attending an overnight school trip. Please note, upper school students are responsible for carrying emergency medications for co-curricular activities (including J-Term and overnight school trips). This privilege DOES NOT apply to controlled medications such as ADD medications or narcotics.

DRUG	ROUTE	DOSAGE	TIMES TO BE GIVEN	SIDE EFFECTS	COMMENTS

★ **PHYSICIAN SIGNATURE:** _____ **DATE:** _____ ★

PHYSICIAN NAME PRINTED: _____ **PHONE:** _____

TO BE COMPLETED BY PARENT/GUARDIAN

MEDICATION DELIVERED TO HEALTH ROOM:

- Medication must be in the original container. Personal over-the-counter medication brought to the health room must also match the information on this form.
- Medications must be personally delivered to the health room by the parent/guardian. Medication must also be picked up by a parent/guardian.
- ***Overnight Field Trips for Grades 6-12:*** If your child takes medication before or after school that you would like for them to receive on overnight trips, we need to have this authorization on file in order to dispense these medications. Medication must be in the original prescription bottle or container. **All medications to be given on field trips must be delivered to the health room at least seven days prior to departure.**

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

Authorization to Treat Statement: I/we the parent(s) or legal guardian(s) of the above-named minor do hereby appoint a Charlotte Christian School representative to act in my/our behalf in authorizing unexpected medical, dental, surgical treatment and/or hospitalization for the above-named minor during our absence for the current school year. The student health record and this document shall be presented to the physician, dentist and/or hospital representative at such time as an unexpected health issue occurs.

★ **PARENTSIGNATURE:** _____ **DATE:** _____ ★

Please make a copy of your student's forms to keep for your records.

ALL MEDICATION WILL BE DISCARDED IF NOT PICKED UP BY MAY 27, 2021.
THE ABOVE MEDICATION ORDER IS VALID FOR ONE YEAR FROM THE DATE SIGNED BY THE PHYSICIAN.