DIOCESE OF CHARLOTTE MEDICATION AUTHORIZATION FORM **School Year**_____

***Attention Parents: This form is so medications can be given to your child at school. NC State law states that for a Nurse or Staff member to administer medications, both prescription AND over the counter (OTC) medication, this form MUST be signed by a Physician and a Parent. You must provide the medication to the school in its original container. The Nurse does not stock over the counter medications. At the end of the school year the medication will be returned to you.**

Student's Name: _____DOB:_____Grade:____Age:____
Weight:_____Allergies:_____

Over the Counter (OTC) Medication (to be provided to school by Parent)

	YES	NO	Dosage	Reason/Side Effects/Comments
Tylenol or generic	____	____	_____	_____
Advil or generic	____	____	_____	_____
Sudafed PE	____	____	_____	_____
Antacids (Tums)	____	____	_____	_____
Throat Lozenges	____	____	_____	_____
Antibiotic ointment	____	____	_____	_____
Cortisone Cream	____	____	_____	_____
Benadryl Cream	____	____	_____	_____
Other_____	____	____	_____	_____

Date Medications to begin: _____ Date Medications to end:_____

Prescription Medication

Medication: _____Reason for medication: _____
Dosage: _____Time: _____Side Effects: _____
Medication: _____Reason for medication: _____
Dosage: _____Time:_____ Side Effects: _____

Date medication to begin: _____Date medication to end: _____

PHYSICIAN AUTHORIZATION

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

PHYSICIAN SIGNATURE: _____ **DATE:** _____
There is a separate form for self-administering Insulin, Epi Pen and Asthma Inhalers to be completed by Physician if child will self carry and self-administer.

PARENTAL/GUARDIAN AUTHORIZATION

I have read the Diocese of Charlotte Medication Regulations on Medication Administration in the school setting that I was provided under separate cover. I am requesting that the above medication be administered as I have indicated. I hereby give my permission for my child (named above) to receive this medication during school hours. I also give my permission for the school nurse and the health care provider listed above to exchange information about the medication and my child's health status. On behalf of my child, I absolve the Diocese of Charlotte, their agents and employees from any liability whatsoever that may result from my child taking this medication.

PARENT/GUARDIAN SIGNATURE:_____**DATE:**_____**PHONE:**_____