DIOCESE OF CHARLOTTE

MEDICATION AUTHORIZATION

This form must be completed in full by the **physician** and signed by the parent/ guardian and physician in order for any **prescription** or **non-prescription medication** to be administered at school. **Please print neatly**.

Student's Name: _____Grade: _____ Age: _____

Weight_____ Allergies_____

Non-Prescription (Over-the-Counter) Medication

Check the medication the student may be given:

	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 Medications

Medication: _____Reason for medication: _____

Dosage: _____Time: _____

Side Effects: _____

Date medication to begin: _____ Date medication to end: _____

Medication: _____Reason for medication: _____

Dosage: _____Time: _____

Side Effects: _____

Date medication to begin: _____ Date medication to end: _____

Medication: _____Reason for medication: _____

Dosage: _____Time: _____

Side Effects: _____

Date medication to begin: _____ Date medication to end: _____

THE BACK OF THIS FORM MUST BE COMPLETED WITH PARENT AND PHYSICIAN SIGNATURE

PHYSICIAN AUTHORIZATION
(REQUIRED)

Printed Physician's Name: _____ Phone: _____Fax:_____

Physician Signature: _____ Date: _____

PARENTAL / GUARDIAN AUTHORIZATION
(REQUIRED)

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: _____

If student is allowed to self administer Insulin, Epi Pen, or Asthma Inhaler, a Self-Medicating Student/Parent/Physician Agreement must be completed.