# 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: _____

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Medication: _____Reason for medication: _____

Dosage: _____Time: _____

Side Effects: _____

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

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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.