The Academy of Coastal Carolina
PHYSICIAN'S AUTHORIZATION FOR MEDICATION AT SCHOOL
To be completed by Healthcare Provider

Name of Student: ________________________________ Birth Date: _____________

Medication: _________________________ Dosage: ______________ Route:______

Time(s) medication to be given or how often: ___________________________________

Significant Information including side effects, toxic reactions, omission reactions:
____

Contraindications for Administration: ____

This medication is to be kept in a locked area and will be provided and transported to and from school by parent or guardian in a container properly labeled by a pharmacist with identifying information (e.g., name of child, medication dispensed, dosage prescribed, route, and the time that it is to be given.

COMPLETE IF PRESCRIBING MEDICATION FOR ASTHMA, ANAPHYLACTIC, OR DIABETIC STUDENTS ONLY

Student may possess and self-administer asthma, anaphylactic, or diabetic medication during the school day and/or school activities. Circle **YES** or **NO**

Student has been instructed, states understanding, and demonstrates skills necessary to possess and self-administer medication at school. Circle **YES** or **NO**

For those students who self-administer medication, backup medication shall be kept at the school per G.S. 115c-375.2. This student has a written treatment plan.

If an emergency occurs during the school day or if the student becomes ill, school officials should call parents, my office or 911.

_____________________________ _________________________ __________
Healthcare Provider Signature **Telephone / Fax Number** **Date**

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PARENT'S PERMISSION

I hereby give permission for my child (named above) to receive medication during school hours. This medication has been prescribed by a licensed physician. I hereby release The Academy of Coastal Carolina and their agents and employees from all liability that may result from my child taking the prescribed medication.

________________________	________________________	___________
Parent or Guardian Signature	**Telephone Number**	**Date**

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STUDENT ACKNOWLEDGEMENT OF SELF-ADMINISTERED MEDICATION

I understand and have demonstrated to the healthcare provider or healthcare provider's staff the skill level necessary to self-administer medication. I agree not to share medication or supplies with anyone.

____ ___________

Student Signature **Date**

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Reviewed by ____ ___________

Academy of Coastal Carolina Personnel **Date**