GASTON COUNTY SCHOOL HEALTH SERVICES

AUTHORIZATION OF MEDICATION FOR STUDENTS IN SCHOOL

(A SEPARATE AUTHORIZATION IS NEEDED FOR EACH MEDICATION)

NAME:_____**BIRTHDATE**_____

DIAGNOSIS:_____

ANY MEDICATION THAT CAN SAFELY BE GIVEN OUTSIDE OF SCHOOL HOURS SHOULD NOT BE REQUESTED TO BE GIVEN AT SCHOOL. No injection will be given except in potentially life-threatening emergencies such as severe allergic reaction or diabetic complication related to insulin reaction. Middle and High school students will be allowed to carry asthma inhalers and EpiPens unless otherwise specified by physician.

MEDICATION:_____

DOSAGE (AMOUNT TO BE GIVEN):_____

RELATIONSHIP TO LUNCH:_____

TIME OR FREQUENCY OF DOSAGE(S) TO BE GIVEN AT SCHOOL:_____

SIDE EFFECTS (EXPECTED OR PREDICTED):_____

DO NOT GIVE MEDICINE IF:_____
AND CONTACT PARENT.

COMMENTS:_____

_____

_____ _____
Physician's Signature (Printed MD name or clinic stamp)

_____ _____ _____
Telephone Date

PARENT'S PERMISSION/RELEASE OF INFORMATION

I hereby give my permission for my child (named above) to receive medication during school hours. I give consent for the school nurse to exchange information with the medical prescriber about medicine administration, dose clarification, response to medication, adverse effects, etc.. On behalf of my child, I absolve the Gaston County Board of Education and their agent and employees from any and all liability whatsoever that may result from my child taking this prescribed medication. I agree to supply the medication as needed.

_____ _____ _____
Parent's Signature Daytime phone number Date

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