AUTHORIZATION FOR PRESCRIPTION MEDICATION FOR STUDENTS FORM

Return completed form to: High School fax: 704-875-2961
Middle School fax: 704-948-8778
Elementary School fax: 704-912-4461

Medications should be administered at home whenever possible. If your physician determines it is necessary for your student to receive medication during the school day, the approval and specific directions must be provided on this form. **If two (2) or more medications are prescribed for the same student, a separate authorization form must be completed for each medication**. The medication must be in a pharmacy bottle/package with a pharmacy label on it. Most pharmacies will provide an extra container and label for school use upon request. New authorization forms must be obtained for each school year or anytime the dosage or directions change. Administration of non-prescription (over the counter) medications at school is discouraged but requires parent consent and must be administered by Health Room/Nursing staff only. Middle school and elementary school students are not allowed to carry medications on their person or keep them in their locker. High school students may carry over the counter medications but not prescription medications. All prescription medications, and over the counter medications for middle school and elementary school students, should be brought to the office immediately upon arriving to school. For questions contact Rebecca Shipman, District Health Care Coordinator at rshipman@LNCharter.org. For elementary school students, contact Denise Linerode, RN at dlinerode@LNCharter.org.

FOR PHYSICIAN'S USE ONLY: *please print legibly*

Student's Name _____

Date of Birth _____ Current Grade _____

Name of Medication _____

Purpose of Medication _____

If this medication is for allergies, what is the student allergic to? _____

Dosage (amount/time to be given) _____

Side effects (expected or predictable, please list) _____

Other instructions (including emergency situations) _____

For Epi Pens, Inhalers, Insulin, and Glucagon Pens: please check all appropriate items. If either item is checked, page 2 of this form must be completed.

____ Please allow this student to self-administer this medication while at school during school hours (must complete page 2 of this form).

____ This student should carry the medication with them at all times during the school day, while at school-sponsored events, or while in transit to or from school or school-sponsored activities (must complete page 2 of this form).

For the health and safety of this child, it is necessary that this medication be given during school hours and/or while at school-sponsored events. The child's parent or guardian knows of this medication request and is in full agreement that Lake Norman Charter personnel will administer this medication.

_____ _____
(Physician's Signature) (Please print Physician's last name)

_____ _____
(Date) (Telephone)

PARENT OR GUARDIAN'S PERMISSION

I hereby give my permission for my child (named above) to receive medication during school hours. I will purchase and supply medication as needed. On behalf of my child, I absolve Lake Norman Charter and their agents and employees from any liability that may result from my child taking this OTC/ prescribed medication at school.

_____ _____ _____
(Parent or Guardian's Signature) (Telephone) (Date)

AUTHORIZATION FOR SELF-MEDICATION BY LAKE NORMAN CHARTER STUDENTS

***For middle school and high school students ONLY**

Student's Name_____ Date of Birth _____

Medication_____ for _____

Eligibility: High school and middle school students with special medical needs such as asthma, severe allergies or diabetes who are subject to anaphylactic reactions, difficulty breathing, or low/high blood glucose levels and may require emergency medications(i.e., asthma inhaler or epinephrine auto-injector ("Epi-pen") and students with diabetes who require insulin to regulate blood glucose levels).

Allergies/Asthma

Physician: The student named above has asthma or an allergy that could result in an anaphylactic reaction and may require emergency medications. The student is capable of, has been instructed on the procedures for, and has demonstrated the skill to self-administer this medication as directed on page 1 of this form. Please allow them to self-administer the medication during school hours and as otherwise indicated on page 1 of this form.
This student *will not* require adult supervision while taking this medication except in emergency situations.

Physician Signature_____ Date _____

Diabetes

Physician: The student named above has diabetes and requires insulin to regulate their blood glucose levels. This student may also require emergency medication if blood glucose levels drop too low. The student is capable of, and has demonstrated the skill to self-administer this medication as directed on page 1 of this form. Please allow them to self-administer the medication during school hours and as otherwise indicated on page 1 of this form. This student *will not* require adult supervision while taking this medication except in emergency situations.

Physician Signature_____ Date _____

Parent/Guardian: I give consent to Lake Norman Charter to allow my child to self-administer this medication at school. I understand that my child and I assume responsibility for the proper use and safekeeping of this medication. If the medication that is prescribed for my child is for the treatment of asthma, anaphylactic reactions, or diabetes, I agree to provide a supplementary supply of the medication that will be kept by the school in a location to which my child has immediate access. I absolve Lake Norman Charter and their agents and employees from any and all liability whatsoever that may result from my child possessing or taking this medication at school. I further consent for information about my child included on pages 1 and 2 of this form to be shared with the appropriate school staff as necessary for the safety of my child.

Parent Signature_____ Date _____

Student: I am capable of taking this medication as recommended and accept this responsibility. I will keep it secured at all times and will not share it with others. I understand that I will be subject to disciplinary action if I abuse the privilege of being allowed to self-medicate while at school or school-sponsored activities.

Student Signature_____ Date _____