Permit for Authorized Personnel to Administer Or Distribute Required Medications During School Hours

THIS PERMISSION MUST BE RENEWED ANNUALLY.

Child's Name: _____ Grade: _____

(TO BE COMPLETED BY PHYSICIAN)

NOTE: CHARLOTTE LAB SCHOOL WILL LIMIT THE MEDICATIONS IT WILL DISPENSE TO THAT WHERE FAILURE TO TAKE PRESCRIBED MEDICATION COULD JEOPARDIZE THE STUDENT'S HEALTH AND/OR EDUCATION. CHARLOTTE LAB SCHOOL WILL ADMINISTER ADD/ADHD MEDICATIONS, ASTHMA, SEIZURE, DIABETIC MEDICATIONS AND OTHER MEDICATIONS SUBJECT TO THE DISCRETION TO REJECT A REQUEST.

Date _____

This child, _____ is under my medical care

for _____, and medication is required

during the school day for the purpose of _____ .

Name of Drug	Dosage	Frequency	Time to be Given at School	Duration	Side Effects

-School Use Only –

Approved: Yes _____

No _____

_____

Principal Date

Signature of Physician: _____

Printed Name of Physician: _____

Physician Address: _____

_____

(City) (State) (ZIP Code)

Emergency Telephone Number: _____

(TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN)

I, _____, give permission for my child to receive the above medication(s) as directed by the physician. The medication will be sent to Charlotte Lab School in a container appropriately labeled by the pharmacy. I will notify Charlotte Lab School in writing if the medication is discontinued. Also, I will obtain a written doctor's order if the medication dosage is changed. I will bring the medication to the Head of School or another designee.

I hereby authorize District Health Staff to contact the medical provider named here _____ regarding this medication and to release information regarding my child (named above) to said provider. I hereby authorize the medical provider to release information about my child and this medication to District Health Staff regarding any medical concerns about this medication order.

I also give permission for the Charlotte Lab School Administration/School Nurse to contact the prescribing health professional about the administration of this medicine. I certify that I have administered at least one dose of the medicine to my child without adverse effects.

Date _____ Parent/Guardian Signature: _____

Address: _____

(City) (State) (ZIP Code)

Primary Phone: _____ Alternate Phone: _____

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