MEDICATION AUTHORIZATION FOR CMS STUDENTS

School Name: Bailey Middle School Telephone: 980-343-1068 Fax: 980-343-1069

To the parent or guardian of _____Birth Date_____

In order to help protect your child's health, your consent and written authorization from a licensed healthcare provider are required when it is necessary for your child to receive either prescription or non-prescription medicines in the Charlotte-Mecklenburg Schools. No medications will be given to your child at school until this authorization has been received. **A separate form is required for each medicine.** New authorization forms are required every year at the beginning of school, whenever the dose or directions change, or when a new medicine is prescribed. It is your responsibility to provide all medicines to be given at school. Each medicine must be in an appropriately labeled original container from the pharmacy or healthcare provider's office. Most pharmacies will provide an extra container for school use upon request. Administration of non-prescription medicines at school is discouraged.

PARENT OR GUARDIAN'S PERMISSION: I give permission for my child to receive the medicine described below during school hours and on the field trip. I understand that it is my responsibility to purchase and supply this medicine. On behalf of my child I absolve the Charlotte-Mecklenburg Board of Education and their agents and employees from any and all liability whatsoever that may result from my child taking this medicine at school.

_____ _____

Signature of parent or guardian Date Contact numbers (pager or mobile, work, home telephone #s)

FOR LICENSED HEALTHCARE PROVIDER USE ONLY: ***please write legibly using lay terms***

Medication prescribed:_____Strength/Dose_____

Specific Directions [include exact amount to give, at what time and/or how often, relationship to meals, specific indications, e.g. if prn (as needed)]:

Purpose of Medication:_____

Relationship to meals, if applicable _____

How often and at what time (hour):_____

Specify side effects or adverse reactions: _____

Other instructions (including emergency situations)_____

_____

Please check all appropriate items. If either of the first two items 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 and on the band trip (must complete page 2 of this form).

This student should carry the medication with him/her 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).

This medication is to be used for emergencies only.

It is necessary for this student to receive this medication during school hours in order to maintain or improve health and to benefit from school attendance. Please notify the principal and/or school nurse and parents/guardians if there are any problems.

_____ _____ _____

Signature of Healthcare Provider Date Telephone Fax

_____ _____

Please print Provider's last name **Practice name or address**

FOR SCHOOL USE ONLY:

Date Received/By: _____School Nurse Review:_____

AUTHORIZATION FOR SELF-MEDICATION BY CMS STUDENTS

Student's Name_____ Birth Date_____

Medication_____for _____

Eligibility: In accordance with CMS Policy JLCD, Administering Medications to Students, and its accompanying regulation, JLCD-R, only students who meet the following descriptions may possess and self-administer medications: (1) Students with special medical needs such as asthma and/or severe allergies or who are subject to anaphylactic reactions and may require emergency medications (i.e., asthma inhaler or epinephrine auto-injector ["Epi-pen"]); and (2) Students who require frequent administrations of non-prescription medications or prescription medications that are not controlled substances.

Healthcare Provider: The student named above has (1) asthma or an allergy that could result in an anaphylactic reaction and may require emergence medications; or (2) a condition that requires frequent administration of a prescription or non-prescription medication. The medication is not a controlled substance. This 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 him/her 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.

Physician signature/date_____

Parent/Guardian: I give consent to the Charlotte-Mecklenburg Schools to allow my child to self-administer this medicine at school. I understand that my child and I assume responsibility for the proper use and safekeeping of this medicine. If the medication that is prescribed for my child is for the treatment of asthma or anaphylactic reactions, 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 the Charlotte-Mecklenburg Board of Education and their agents and employees from any and all liability whatsoever that may result from my child possessing or taking this medicine at school. I further consent for the information about my child included on pages 1 and 2 of this form to be shared with appropriate school staff as necessary for the safety of my child.

Parent signature/date _____

Student: I am capable of taking this medicine as recommended and accept this responsibility. I will keep it secure at all times and will not share it with others. I understand that I will be subject to discipline under the Student Code of Conduct if I abuse the privilege of being allowed to self-medicate while at school or school-sponsored activities. Unless the medication is prescribed for the treatment of asthma or anaphylactic reactions, I understand that I will lose the privilege of self-administering my medication if I do not follow these rules.

Student signature/date _____
