Queen's Grant High School
Medication Authorization Form

Student Name _____ **Date of Birth** _____

Written parent/guardian consent and an order from a healthcare provider licensed in North Carolina are required for administering prescription and over-the-counter medications at school.

SECTION 1: LICENSED HEALTHCARE PROVIDER AUTHORIZATION	
Medication: (Generic/Brand)	Controlled Substance? ❒ Yes ❒ No
Dose/Dosing Instructions:	
Administration Time: Relationship to meals: ❒ Not applicable ❒ With snacks ❒ With meals ❒ Other:	❒ PRN (specific time interval):
Purpose:	❒ Check here if medication is to be used for emergencies only
Side Effects/Adverse Reactions:	
Anticipated length of treatment: ❒ School Year ❒ ____ Weeks ❒ ____ Months ❒ ____Days	Other Instructions (including emergency situations):

In my professional opinion, it is medically necessary for this student to receive this medication during school hours.

Signature of Healthcare Provider: _____ Date: _____

Stamp, Print or Type Healthcare Provider's Name & Address	Office Phone
	Office Fax

SECTION 2: PARENT/LEGAL GUARDIAN CONSENT

I understand:

- No medication will be given at school until this authorization has been approved by administration. New authorization forms are required at the beginning of every school year, when the dose or directions change, and when a new medication is prescribed. It is my responsibility to supply the medication. Each medication must be in the original labeled container from the pharmacy or healthcare provider's office. Some pharmacies will provide an extra container for school use. Information about this medication and my child's health may be shared with school staff or agents of the school to help assure my child's safety and success at school. The school medical coordinator may contact the healthcare provider who prescribed the medication and the pharmacy where the prescription was filled to discuss this medication and my child's health. Medications are given by a trained staff member.
- I give permission for my child to receive the medication described below during school hours. I give permission for the healthcare provider, pharmacist and their staff to provide information to the school about this medication and my child's health.
- On behalf of my child, I release Queen's Grant High School, their agents and employees from any and all liability whatsoever that may result from my child taking this medication at school.

Parent/Legal Guardian Signature:	Date:
Parent/Legal Guardian (Print Name):	Phone Numbers (cell, work, home):

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SECTION 3: AUTHORIZATION FOR SELF-MEDICATION BY QGHS STUDENTS

Student's Name_____ Date of Birth _____

Medication:	Purpose of Medication:

ELIGIBILITY

Students with chronic conditions such as asthma, diabetes, severe allergies and those who require frequent doses of non-prescription products, may be eligible to self-medicate. Self-administration of a controlled substance will be considered in rare instances where potentially harmful medical episodes may occur. For self-medication, students: 1) must be mentally, emotionally, and physically capable of self-administering medication, 2) must have been instructed in proper use and safe-keeping of their medications, 3) must demonstrate mature and responsible behavior using their medication 4) must keep their medication secure on their own person or in some other manner agreed upon with the school nurse and the school administration, and 5) must not share medication with or display to other students. The privilege of being allowed to self-medicate may be taken away if there is any just cause. Failure to follow policies and regulations may result in disciplinary actions as noted in the Student Code of Conduct. QGHS, its designees and agents, do not assume responsibility for self-medication by students.

HEALTHCARE PROVIDER

The student named above meets the eligibility requirements for self-medication. This student is capable of, has been instructed on the procedures for, and has demonstrated the skill to self-administer this medication as directed in Section 1 of this form. This student will not require adult supervision while taking this medication.

Is this substance a controlled substance? ❒ yes ❒ no

Check applicable items below:
❒ Please allow this student to self-administer this medication while at school during school hours.
❒ This student should carry this 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 events.

Healthcare Provider Signature:	Date:
Healthcare Provider (Print Name):	

PARENT/LEGAL GUARDIAN

My child is capable of self-medicating and meets the eligibility requirements. I give consent to Queen's Grant High School 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 this medication is for a life-threatening emergency such as anaphylaxis or asthma, I understand that providing an extra supply of the medication to be kept at school is strongly recommended to assure the medication is available in case my child forgets to bring it to school or loses it. I release Queen's Grant High School, their agents and employees from any and all liability whatsoever that may result from my child carrying or taking this medication at school. I understand that information about this medication and my child's health may be shared with other school staff and agents of the school to help assure my child's safety and success at school. The school nurse may contact the healthcare provider who prescribed the medication and the pharmacy where the prescription was filled to discuss this medication and my child's health.

Parent/Legal Guardian Signature:	Date:
Parent/Legal Guardian (Print Name):	

STUDENT

I am capable of taking this medication on my own. I agree to take this medication as ordered. I will keep it safe and out of the sight of others when I am not using it. I will not let others hold or use my medication or medical supplies. I understand that I will be disciplined under the Student Code of Conduct if I abuse the privilege of being allowed to self-medicate while at school or school sponsored activities. I understand that I may lose the privilege of self-administering my medication if I do not follow these rules.

Student Signature:	Date:
Student (Print Name):	