GUILFORD COUNTY SCHOOLS
AUTHORIZATION OF MEDICATION FOR A STUDENT AT SCHOOL

Check one: _____ Prescription _____ Non-Prescription

School: _____School Address_____

Name of Student: _____ Date of Birth_____

IN ORDER TO KEEP THIS STUDENT IN OPTIMUM HEALTH AND TO HELP MAINTAIN MAXIMUM SCHOOL PERFORMANCE, IT IS NECESSARY THAT MEDICATION BE GIVEN DURING SCHOOL HOURS.

Northwest Pediatrics
4529 Jessup Grove Rd.
Greensboro, NC 27410
Phone: 336-605-0190

Prescribing Health Care Clinician Janet Dees, MD, Jennifer Summer, MD, Melody DeClaire, MD, Rachel Mills, PNP, Elizabeth Christy, FNP, Heidi Smoot, FNP, Donna Brandon, PA-C, Angela Bracken, PA, Heather Parrish, FNP, Ekaterina Vapne, MD, David DeWeese, MD, Jenny Riddle, FNP

Medication: _____ Diagnosis :_____

Dosage and Frequency (amount to be given and time):_____

Expected dates for Administration: 2019-2020 School year

Possible Adverse Reactions That Should Be Reported to Health Care Clinician: _____

☐ Check here if serious reaction can occur if medication not given exactly as prescribed.

☐ Check here if serious reaction can occur even when medication administered properly.

☐ Student has been instructed, understands and has demonstrated the skill to self administered his/her emergency medication.

Special Handling Instructions: _____

NOTE: The health care clinician may use another format (computer printout, letter, etc.) to authorize administration of the medication. However, all information requested above must be provided.

_____ 336-605-0190
Signature of Health Care Clinician Date Phone

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PARENTS PERMISSION

I hereby give my permission for my child (named above to receive medication during school hours. This medication has been prescribed by a licensed physician or other health care clinician. I hereby release the Board of Education and their agents and employees from any and all liability that may result from my child taking the prescribed medication.

_____ _____ _____
Signature of Parent or Guardian Date Phone

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(SCHOOL USE ONLY)

Name and title of person(s) designated by principal to administer medication:_____

_____

☐ Student has demonstrated to the school nurse the skill to self administer his/her emergency medication.

Content reviewed by: _____
Signature of School Health Nurse Date

Withdrawal of authorization was made in writing (attach note from parents) Date:_____