

PHYSICIAN'S AUTHORIZATION OF MEDICATION FOR A STUDENT AT



**GRAY STONE**  
DAY SCHOOL



Physician's Authorization Form must be completed, signed by physician and parent for medication to be given at school. Prescription medication must be in the most current pharmacy labeled container. Over-the-counter medication must be provided in unopened original container. A new form must be completed each year or if prescription changes. Medication will not be administered on delayed days/early release days if outside of scheduled medication window. If medication is not picked up by last day of school, it will be disposed.

STUDENT: \_\_\_\_\_

GRADE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

MEDICATION: \_\_\_\_\_ (one medication per form)

DOSAGE AND ROUTE: \_\_\_\_\_

TIME(S) TO BE GIVEN AT SCHOOL: \_\_\_\_\_ PRN: \_\_\_\_\_

Significant Info (side effects, toxic rxn, reaction if omitted, etc.): \_\_\_\_\_

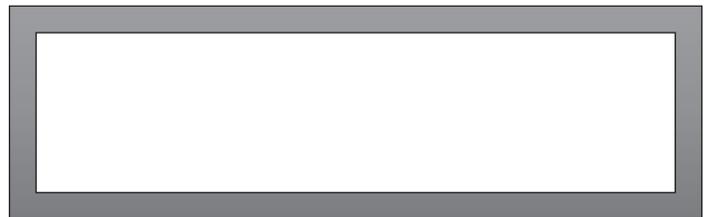
Contraindications for Administration: \_\_\_\_\_

**Student Self Administration of Medications (For Physician's use ONLY)**

Asthma inhalers, epinephrine (epi pens) and diabetic supplies may be carried & self-administered according to NC law with a physician's signature. Parent must provide an extra of the listed medication in case of an emergency.

\_\_\_\_\_  
(physician's initials) I agree this student demonstrates the knowledge & skill necessary to self-medicate (limited to asthma inhalers, epi pens and diabetic supplies)

Clinic Stamp



\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone

*I hereby give permission for my child (named above) to receive this medication. I understand that the school undertakes no responsibility for administration of the medication. This medication has been prescribed by a licensed physician. I hereby release Gray Stone Day School and its employees from any and all liability which may result from my child taking the prescribed medication.*

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Parent/Guardian's Signature

**FOR SCHOOL ONLY**

Individuals to Administer Drug: \_\_\_\_\_

Reviewed By: \_\_\_\_\_  
Principal

\_\_\_\_\_  
Date

Reviewed By: \_\_\_\_\_  
School Nurse

\_\_\_\_\_  
Date