Charlotte-Mecklenburg Schools

MEDICATION AUTHORIZATION FOR CMS STUDENTS

School Name	School Phone #	For School Use Only
		Date Received/Receiver's Signature: Medication Received? ❒ yes ❒ no
If submitting by fax: 704-432-2079 (School Health)		
Student's Name (Please print.)	Student's Date of Birth	Date Approved/Nurse's Signature Entered in EHR? ❒ yes ❒ no

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 (CMS Policy JLCD/Regulation JLCD-R). Contact the school nurse for help if relocating from another state with orders from an out-of-state provider. Some medications may not be suitable for a school setting. Additional documentation may be required for some medications (examples: research medications, medications with potential for immediate serious side effects). Contact the school nurse if you have questions.

SECTION 1: LICENSED HEALTHCARE PROVIDER AUTHORIZATION

- When possible, medications should be taken before or after school. Administration of non-prescription medications at school is discouraged.
- CMS action plans for asthma, diabetes, seizure disorders and severe allergies may be used instead of this form. See CMS Coordinated School Health webpage.
- When using this form, complete a separate form for each medication; write legibly; use lay terms.
- Complete Section 3 for students who will self-carry and/or self-medicate.

Medication: (Generic/Brand)	Controlled Substance? ❒ yes ❒ no
Dose/Dosing Instructions:	Route:
Administration Time: Relationship to meals: ❒ Not applicable ❒ With meals ❒ With snacks ❒ Other:	❒ PRN (specify time interval):
Purpose:	Check here if this medication is to be used for emergencies only. ❒
Side Effects/Adverse Reactions:	
Anticipated length of treatment: ❒ School Year ❒ _____ Months ❒ _____ Weeks ❒ ____ 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 a school nurse. 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 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. Medications are given by a nurse or trained CMS staff.
- I give permission for my child to receive the medication described above during school hours. I give permission for the healthcare provider, pharmacist and their staff to provide information to the school nurse about this medication and my child's health.
- On behalf of my child, I release the Charlotte-Mecklenburg Board of Education, 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:	Phone Numbers (mobile, work, home):
Parent/Legal Guardian (Print Name):	

Please complete form and return to your student's school.