GASTON CHRISTIAN SCHOOL

MEDICATION AUTHORIZATION

*No medications (non-prescription/over the counter or prescription) will be administered by the school nurse, other school personnel or self (student) without the written authorization of a **physician and parent**.*

Student's Name_____**Grade**_____

Drug Allergies_____

Date of Birth_____**Height**_____**Weight**_____

Parent Complete

I, _____(do☐) (do not☐)authorize my child's health care provider and the school nurse to discuss my child's health concerns and/or exchange information pertaining to school health forms. *This authorization will be in place until or unless you withdraw it. You may withdraw your authorization at any time by contacting your child's school.* **I authorize the medication(s) checked below by the care provider to be given as ordered to my child.**

Signature of parent/legal guardian_____Date_____

Physician/Provider Complete

The over the counter medication dosage will be administered according to the manufacturer's recommendations on the label unless otherwise indicated by a physician. Generic substitutions may be used for non-prescription medications listed. This form will also be the authorized form used for off campus activities, including overnight trips.

Non-prescription medication stocked in office include the following (**please check** those that are to be given as needed):

☐Tylenol (Acetaminophen) ☐Motrin (Ibuprofen) ☐Benadryl

☐Cough drops ☐Tums/Pepto-Bismol

☐Neosporin/Hydrocortisone lotion/Benadryl spray and lotion/topical sting relief

Please list **any other medication** which would need administering during school or school related activities, whether to be administered by school personnel or self (student).

Name of medication_____Dosage_____

Route_____Hours to be given_____

Student may carry and self administer the medication ordered: yes☐ no☐

Physician/Nurse Practitioner/PA

Signature_____Date_____