

GASTON COUNTY SCHOOL HEALTH SERVICES

AUTHORIZATION OF MEDICATION FOR STUDENTS IN SCHOOL (A SEPARATE AUTHORIZATION IS NEEDED FOR EACH MEDICATION)

NAME: _____ BIRTHDATE _____

DIAGNOSIS: _____

ANY MEDICATION THAT CAN SAFELY BE GIVEN OUTSIDE OF SCHOOL HOURS, SHOULD NOT BE REQUESTED TO BE GIVEN AT SCHOOL. No injection will be given except in potentially life-threatening emergencies such as severe allergic reaction or diabetic complication relation to insulin reaction. Middle and High school students will be allowed to carry asthma inhalers and EpiPens unless otherwise specified by physician.

MEDICATION: _____

DOSAGE (AMOUNT TO BE GIVEN); _____

RELATIONSHIP TO LUNCH: _____

TIME OR FREQUENCY OF DOSAGE(S) TO BE GIVEN AT SCHOOL: _____

SIDE EFFECTS (EXPECTED OR PREDICTED): _____

DO NOT GIVE MEDICINE IF: _____
AND CONTACT PARENT.

COMMENTS: _____

Physician's Signature

(Printed MD name or clinic stamp)

Telephone

Date

PARENT'S PERMISSION

I hereby give my permission for my child (named above) to receive medication during school hours. On behalf of my child, I absolve the Gaston County Board of Education and their agent and employees from any and all liability whatsoever that may result from my child taking this prescribed medication. I agree to supply the medication as needed.

Parent's Signature

Daytime phone number

Date

RELEASE OF INFORMATION

I hereby give permission for school personnel to contact my child's physician and exchange information regarding my child's health needs.

Signature of parent or guardian

Daytime phone number

Date