Clinic Medication Authorization Form

CHEROKEE CHARTER ACADEMY

STUDENT NAME _____ **DOB** _____

GRADE _____ **HOMEROOM TEACHER** _____

PARENT/GUARDIAN NAME _____

PRIMARY CONTACT # _____ **SECONDARY #** _____

PRIMARY PHYSICIAN _____ **PCP PHONE #** _____

MEDICAL HISTORY – PLEASE CHECK IF YOUR CHILD HAS EVER HAD ANY OF THE FOLLOWING:

	NOW	PAST
Asthma		
Diabetes		
Seizures / Epilepsy		
Heart Problems		
Headaches		
Skin Diseases		
Seasonal Allergies		

	NOW	PAST
Allergies Requiring Epinephrine Injection		
Nosebleeds		
Respiratory Problems		
Cancer		
Kidney Problems		
Blood Disorders		
Other:		

PLEASE DESCRIBE OTHER MEDICAL PROBLEMS: _____

_____

_____

DOES YOUR CHILD HAVE ANY MEDICAL PROCEDURES THAT WILL NEED TO BE PERFORMED DURING THE SCHOOL DAY?

☐ **YES** ☐ **NO** IF YES, PLEASE LIST: _____

_____

DOES YOUR CHILD HAVE ALLERGIES TO FOODS OR INSECTS? ☐ **YES** ☐ **NO** IF YES, PLEASE LIST: _____

_____

HAS AN EMERGENCY EPINEPHRINE INJECTOR ***EVER*** BEEN USED ON YOUR CHILD DUE TO AN ALLERGIC REACTION?

☐ **YES** ☐ **NO** IF YES, FOR WHAT ALLERGY: _____

PLEASE LIST ANY MEDICATIONS THAT YOUR CHILD IS TAKING THAT THE SCHOOL NURSE OR STAFF NEED TO BE AWARE OF:

_____

_____

THE SCHOOL CANNOT ADMINISTER ANY MEDICATION UNTIL A MEDICATION AUTHORIZATION FORM HAS BEEN COMPLETED FOR *EACH* MEDICATION. MEDICATIONS MUST BE PROVIDED BY THE PARENTS/GUARDIANS.

PARENT SIGNATURE _____ DATE _____

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GRADE _____ HOMEROOM TEACHER _____

PARENT/GUARDIAN NAME _____

PRIMARY CONTACT # _____ SECONDARY # _____

PRIMARY PHYSICIAN _____ PCP PHONE # _____

REASON MEDICATION WILL BE TAKEN _____

THE ADMINISTRATION OF CONTROLLED MEDICATIONS AND/OR MEDICATIONS WHICH ALTER VITAL SIGNS OR LEVELS OF CONSCIOUSNESS WILL BE EVALUATED ON AN INDIVIDUAL BASIS BY THE SCHOOL NURSE AND/OR ADMINISTRATION.

MEDICATION AND STRENGTH _____ AMOUNT TO BE TAKEN _____

TIME(S) MEDICATION IS TO BE TAKEN _____ AS NEEDED _____ EVERY _____ HOURS

HOW WILL THE MEDICATION BE ADMINISTERED? BY MOUTH _____ EYE DROPS _____ EAR DROPS_____
TOPICAL (ON THE SKIN) _____ OTHER_____

THE BEFORE AND AFTER SCHOOL PROGRAM REQUIRES A SECONDARY LABELED PHARMACY CONTAINER FOR PRESCRIPTION MEDICATIONS TO BE ADMINISTERED BY THE BEFORE/AFTER SCHOOL PROGRAM. THE PRIMARY CONTAINER WILL BE KEPT IN THE CLINIC.

PRESCRIPTION MEDICATION MUST BE IN THE ORIGINAL PHARMACY CONTAINER. THE WRITTEN INSTRUCTIONS ON THE CONTAINER FOR DOSAGE AND ADMINISTRATION TIMES WILL BE FOLLOWED. A NEW CONTAINER MUST BE PROVIDED FOR CHANGE IN DOSE OR TIME.

OVER-THE-COUNTER (OTC) MEDICATIONS MUST BE IN AN ORIGINAL SEALED CONTAINER. DOSAGE WILL NOT EXCEED INSTRUCTIONS ON THE LABEL REGARDLESS OF PARENT INSTRUCTIONS. OTC MEDICATIONS WILL BE GIVEN FOR ONLY *7 CONSECUTIVE DAYS*. A PHYSICIAN'S APPROVAL FORM MUST BE COMPLETED FOR LONGER TREATMENT.

PLEASE NOTE *NO* MEDICATIONS WILL BE HELD OVER THE SUMMER ONCE THE SCHOOL YEAR HAS ENDED. ALL MEDICATION MUST BE PICKED UP BY A PARENT/GUARDIAN. *NO MEDICATIONS WILL BE SENT HOME WITH STUDENTS AND THE COMPLETION OF THE SCHOOL YEAR. ANY* MEDICATIONS NOT PICKED UP BY A PARENT BY THE LAST DAY OF SCHOOL WILL BE DISPOSSED OF.

I AUTHORIZE THE PERSONNEL OF CCA TO ASSIST MY CHILD IN TAKING MEDICATION. I HEREBY RELEASE AND WAIVE, AND FURTHER AGREE TO INDEMNIFY, HOLD HARMLESS OR REMBURSE THE CHEROKEE COUNTY BOARD OF EDUCATION, THE INDIVIDUAL MEMBERS, AGENTS, EMPLOYEES AND REPRESENTATIVES THEREOF, FROM AN AGAINST, ANY CLAIM WHICH I, ANY OTHER PARENT OR GUARDIAN, ANY SIBLING, THE STUDENT, OR ANY OTHER PERSON, FIRM OR CORPORATION MAY HAVE OR CLAIM TO HAVE, KNOWN OR UNKNOWN DIRECTLY OR INDIRECTLY, FOR ANY LOSES, DAMAGES OR INJURIES ARISING OUT OF, DURING OR IN CONNECTION WITH THE ADMINISTERING OF THIS MEDICATION.

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____