Triad Math and Science Academy Elementary
600 Industrial Ave. Greensboro, NC 27406
336-763-2771 (phone) 844-365-8672 (fax)

Authorization of Medication for a student at school

Check one: _____ Prescription ____Non-Prescription

Name of Student: _____ Date of Birth: _____

IN ORDER TO KEEP THIS STUDENT IN OPTIMUM HEALTH AND TO HELP MAINTAIN MAXIMUM SCHOOL PERFORMANCE, IT IS NECESSARY THAT MEDICATION BE GIVEN DURING SCHOOL HOURS.

Prescribing Health Care Clinician: _____ Phone: _____

Medication: _____ Diagnosis _____

Dosage and frequency (amount to be given and time): _____

Expected Dates for Administration: _____

Possible Adverse Reactions that should be reported to Health Care Clinician:

_____

____ Check here if serious reaction can occur if medication not given exactly as prescribed.

____ Check here if serious reaction can occur even when medication is administered properly.

Actions to be taken if adverse reaction occurs: _____

Special handling instructions: _____

NOTE: The health clinician may use another format (computer, printout, letter, etc) to authorize administration of the medication. However, ALL information requested above must be provided.

_____ _____ _____

Signature of Health Clinician Date Telephone Number

NO INJECTION WILL BE GIVEN EXCEPT IN EXTREME EMERGENCY,

SUCH AS ALLERGY TO WASP OR BEE STING

PARENTS PERMISSION

I hereby give my permission for my child (named above) to receive medication during school hours. I understand that the school undertakes no responsibility for the administration of the medication. This medication has been prescribed by a licensed physician or other health care clinician. I hereby release the Board of Directors and their agents and employees from any and all liability that may result from my child taking the prescribed medication.

_____ _____ _____

Signature of Parent or Guardian Date Telephone Number