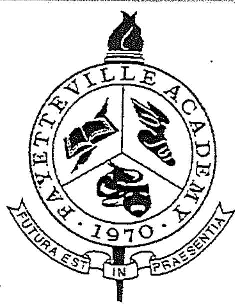

Fayetteville Academy

3200 Cliffdale Road • Fayetteville, North Carolina 28303

SCHOOL MEDICATION FORM

School:_______________ Telephone: _______________ Fax: _______________

Student Name____Birthdate_____________________

Teacher/Grade____

In order to help protect your child's health, your consent **and** written authorization from a health care provider with prescriptive authority is required when it is necessary for your child to receive prescription and/or non-prescription medicines.

Parent or Guardian's Permission: I give permission for my child to receive this medicine during school hours. I also give permission for school staff to contact the prescribing healthcare provider with questions/concerns. I understand that it is my responsibility to purchase and supply this medicine in its original container. On behalf of my child I absolve the Fayetteville Academy Board and their agents and employees from any and all liability whatsoever that may result from my child taking this medicine at school.

____ ____

Signature of parent or guardian Date Contact numbers (telephone, cell phone, pager, etc.)

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Medication____Strength/Dose_____________________

Medical Diagnosis: ____

Specific Directions (include amount to give, at what time and/or how often, relationship to meals, specific indications if "as needed")

How often and/or at what time (hour):____

Purpose of medication: ____

Relationship to meals, if applicable: ____

Expected side effects or adverse reactions: ____

Specific indications: ____

Other information: ____

It is necessary for this student to receive this medication during school hours in order to maintain or improve health and to benefit from school attendance. Please notify the principal and/or school nurse and parents/guardians if there are any problems.

____ _______________ _______________ _______________

Signature of Healthcare Provider Date Telephone Fax

____ ____

Please print practitioner's last name **Practice name /address**

- -

FOR SCHOOL USE ONLY:

Date Received/By: _________________________________School Health Nurse Review: _____________________

Location of Medicine ☐ on student, emergency medication only ☐ in Health room ☐ in Classroom