TMSA Triad Elementary
600 Industrial Ave., Greensboro, NC 27406
Phone: 336-763-2771 | Fax: 844-365-8672

Authorization of Medication for a Student at School

Check One: ___ Prescription ___ Non-Prescription

Student's Name: _____ Date of Birth: _____

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

Prescribing Health Care Clinician: _____ Phone: _____

Medication: _____ Diagnosis: _____

Dosage / 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 a serious reaction can occur if medication is not given exactly as prescribed.
___ Check here if a 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 the 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 AN EXTREME EMERGENCY, SUCH AS AN ALLERGY TO A WASP OR BEE STING.

PARENT'S 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