COTSWOLD PEDIATRICS

3030 Randolph Rd, Suite 102 Charlotte, NC 28211
Phone: 704-512-4475, Fax: 704-512-4478

MEDICATION AUTHORIZATION FOR STUDENTS

Student's Name: _____ Birthdate: _____

Medication: _____ Strength/Dose: _____

Purpose of Medication: _____

Relationship to meals, if applicable: _____

How often and at what time (hour): _____

Expected side effects or possible adverse reactions: _____

_____

Termination Date: _____

In order to keep this child in optimum health and to maintain school performance, it is necessary that medication be given during school hours. The child's parent or guardian knows of this medication request and is in full agreement that this medication will be administered by acting authorities or personnel of attending facility.

_____ _____

Provider Signature *Date*

PARENT OR GUARDIAN PERMISSION

I hereby give my permission for my child (named above) to receive medication during school hours. I will purchase and supply said medicine as needed. On behalf of my child, I absolve the attending facility and any of their agents and employees from any and all liability whatsoever that may result from my child taking this prescribed medication.

_____ _____

Parent Signature *Date*