

Student Medication Authorization Form

Complete only if necessary. Please fill out one form for each medication.

This section is to be completed by student's doctor prior to class.

Student's Name _____ Birthdate _____

Module Attending _____ Module Dates _____

Medication _____ Dosage _____

Time of Day to be administered _____

Purpose of Medication _____

Special Instructions _____

Signature of Doctor or person with prescriptive authority Date

Phone Number _____

Printed Name

Note: All medication brought to class must be in the original container which clearly states the child's name, the health care provider, name of medication, date, and dosage. This applies to prescriptions as well as over-the-counter medications. Class personnel are not responsible for the administration or control of the medication. All students must be able to self-administer their required medication. All medications must be taken home overnight and are not to be left on site.

This section is to be completed by student's parent or guardian prior to camp/class.

I hereby give my permission for _____ to take medication listed on this form. I understand it is my responsibility to furnish the medication in the original container which clearly states the child's name, the health care provider, name of medication, date and dosage.

Signature of Parent or Guardian Date

Printed Name

Phone _____ Mobile _____

Please email completed forms to info@youth.cpcc.edu, fax to 704.330.6810, or mail by postage to CPCC Services Corporation, PO Box 35009, Charlotte, NC, 28235. Thank you.