Southwest Charlotte STEM Academy

Prescription Medication Authorization Form
Southwest Charlotte STEM Academy
5203 Shopton Road Charlotte, NC 28278
980-505-8344 (Phone)
www.scstemacademy. Org

To the **Parent/Guardian of**:_____ Birth date: _____

In order to help protect your child's health, your consent and written authorization from a licensed health care provider are required when it is necessary for your Southwest Charlotte STEM Academy (SCSA) student(s) to receive prescription medications during school hours (including overnight field trips). A separate form is required for each medication. New authorization forms are required at the beginning of each school year, whenever the dose or directions change, or when a new medication is prescribed. Each medication must be in an appropriately-labeled, original container from the pharmacy or health care provider's office. Most pharmacies will provide an extra container for school use upon request.

I give permission for my child to receive this medication during school hours (including overnight field trips). I understand that it is my responsibility to purchase and supply the medication, and that SCSA employees are acting on my behalf during school hours.

Parent Signature: Date: _____

_____

_____

Telephone Contact Number:

_____

Health Professional Section

Medication Prescribed:_____Strength/dose: _____

Specific directions (include condition being treated by this medication, exact amount to give, at what time and/or how often, relationship to meals, specific indication if PRN, etc.):

_____

_____

Potential Side Effects and/or Adverse Reactions:

_____

Other Instructions (please check all that apply):

- ☐ It is necessary for this student to receive this medication during school hours in order to maintain or improve health and maximize opportunities for learning.
- ☐ This medication is to be used for emergencies only.
- ☐ This student should carry this medication with him/her at all times.
- ☐ This medication may be self-administered by the student.

Signature of Health Care Provider:_____ Date: _____

Printed Name of Health Provider: _____

Practice Name: _____

Date received by Southwest Charlotte STEM Academy:_____