Notice & Authorization of Medication to be Given During School Hours

Student's Name: _____DOB:_____

This form is to be signed by the physician AND parent if the medication is to be given during school hours and if there are any changes to the medications. Please take this form to your physician, who will list all necessary medications. Please sign and return to New Independence Academy. Notify the school immediately if there are any changes.

1. Name of medication: _____

Dosage: _____ Time(s) Given: _____

How medication given: _____

Reason medication given: _____

Side effects that may impact student's learning or behavior:
_____

2. Name of medication: _____

Dosage: _____ Time(s) Given: _____

How medication given: _____

Reason medication given: _____

Side effects that may impact student's learning or behavior:
_____

New Independence Academy
PO Box 125
Pikeville, NC 27863
(919) 288-2429

3. Name of medication: _____

Dosage: _____ Time(s) Given: _____

How medication given: _____

Reason medication given: _____

Side effects that may impact student's learning or behavior:
_____

This will serve as a prescription for the individual named above:

Prescribing physician: _____Phone:_____

Signature of Physician_____

Date:_____

I authorize New Independence Academy staff to administer the above medication(s) to my child as specified above. The authorization is valid from: _____to _____
(no more than a year). I give consent to the director to communicate with the child's physician and counsel the school personnel on the possible side effects of my child's medication

_____ _____
Signature of Parent/Guardian Date

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