Hobgood Charter School
2024-2025 School Year
AUTHORIZATION FOR MEDICATION

TO BE COMPLETED BY PHYSICIAN/MEDICAL PROVIDER

Date: ____________________

Name of Student: ___________________________

Date of Birth: _____________

School: ____________________________________

It is necessary that medications be given during school hours in order to keep this student in optimum health and to help maintain school performance.

TO BE COMPLETED BY MEDICAL PROVIDER

Medication: ___________________________________ **Dosage/mg:** ________________ **Route:** ________________

Time(s) medication is to be given at SCHOOL _____________________ **Date to be given from** ______ **to** ______

***Providers please note that "lunch time" can vary from 10:30 am to 1:30pm**

***If medication is ordered as needed, please indicate specific circumstances when medication should be given (School staff, not licensed medical or nursing personnel, will be administering medication):**
____
____
____

Significant information: (side effects, toxic reactions, omissions):

____

For K-12 students authorized to carry and administer rescue medications: Asthma Inhalers, EpiPen or Diabetic insulin and glucose monitor. Please check the appropriate box.

☐ May self-carry and self-medicate (student has demonstrated proficient use of medication)*

☐ May ***not*** self-carry and self-medicate.

_______________________________________ ____________________________
Medical Provider's Signature (MD, PA, FNP) **Telephone Number**

TO BE COMPLETED BY PARENT

I hereby give permission for my child, __________________________________ to receive medication during school hours. This medication has been prescribed by a licensed physician. I hereby release the Edgecombe County Board of Education and their agents and employees from any and all liability that may result from my child taking the medication.

☐ May self-carry own medicine and self-medicate* ☐ May ***not*** self-carry or self-medicate

_____________________________ _____________________________ _____________________________
Signature of Parent / Guardian & Date **Parent Telephone Number** **Signature of Nurse & Date**

School assumes no responsibility for students who self-carry and self-medicate per policy