Cabarrus Charter Academy
Student Health Services

Supervised Medication Administration Authorization
School Year _______________

Student_____________________________________Date of Birth___________Grade_________Teacher________________

Parent/Legal Guardian_________________________Email ____________________________Phone#______________________

To be completed by Health Care Provider

Medication____Dosage____________Route________Time(s) to give_______________
Reason for medication____Start Date__________Stop Date_____________
Side effects/precautions____

______ I recommend this medication be administered by trained school staff. [1]

______ Student is capable of safely carrying/administering this medication on his/her own. [2]

[1] Medication classified as controlled, stimulant, or narcotic medication must be administered/supervised by staff.

[2] Cabarrus Charter Academy accepts no responsibility or liability for students who self-medicate.

Provider signature____
Print name____
Phone_____________________Fax__________________Date______________

Stamp - optional

To be completed by Parent/Guardian

My signature in the space below assures that:

1) I hereby give my permission for my child (named above) to receive this (stated) medication at school;
2) I assume full responsibility and will inform school staff of any medication changes or health status;
3) I hereby release CCA Board, their agents, and employees from any and all liability that may occur as a result of medication administration;
4) I will provide a new medication form each school year and each time the dose/medication changes;
5) I agree to furnish medication in an original, properly labeled pharmacy or store container;
6) I will provide the school back-up medication, if my child self-medicates, to be kept in the school health office that my child can access in case of an emergency.
7) I will pick-up any unused/discontinued medication as indicated during (or by end of) the school year- if not, the school may dispose of the medication; and,
8) I acknowledge that, if healthcare provider indicates self-medication by my child, that he/she will safely carry and administer the medication, and will not share this medication with anyone.

Signature of parent/guardian ____Phone____________________Date____________

To be completed by School Nurse

☐ Yes ☐ No ☐ N/A Student demonstrates knowledge, ability, and responsibility to safely keep, carry, and administer med.

☐ Yes ☐ No ☐ N/A Auxiliary staff notified; list:____________________________________

List staff trained to administer this medication____

Comments____

Signature of school nurse____Date _________________

To be completed at the end of the year

Medication picked up by____Relationship to student_______________________

Number of pills (if controlled substance) ___________________________Date____

CCA Staff Member____

Original to school nurse. Copies to school administration and teachers.

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