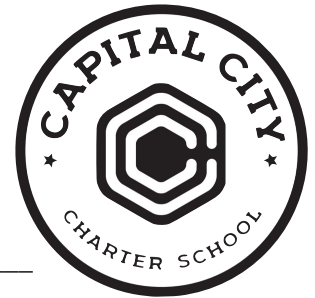


2019 -2020 Authorization for Medication



Student's Name: _____ Date of Birth: _____

Parents and students are required to provide Capital City Public Charter School Office with a list of all medications that are currently used by the student. This information should be provided in the spaces below. In accordance with CCCS's Health policy, students may have the following medications with parental and prescriber permission. CCCS reserves the right to revoke a student's right to self-administer medication when, in the professional judgment of the Health Center's medical staff, the student has demonstrated an inability to self-medicate safely.

Class I—Non-Prescription Medications

Any non-prescription medications such as dietary supplements, vitamins, herbal remedies, and over-the-counter (OTC) medications

Class 2—Topical Prescribed Medications and Certain Oral Prescribed Medications

Typically applied creams for the treatment of acne, oral antibiotics, oral contraception and medications for the treatment of allergies

Class 3—Emergency Medications

Asthma inhalers, epinephrine auto-injectors, insulin, and other similar emergency medications

THE FOLLOWING CLASSES OF MEDICATIONS MUST BE HOUSED AND ADMINISTERED ON A DOSE-BY-DOSE BASIS BY THE SABRA M. HAMILTON HEALTH CENTER NURSE:

Class 4—Narcotic, Stimulant, and Psychotropic Medications

Class 5—Other Prescription Drugs (not otherwise classified)

List all prescription medications and their dosages that your child is taking.

MEDICATION	DOSAGE/INSTRUCTION	DIAGNOSIS/REASON FOR MED

Medication Consent for Self-Administration

Would you like your child to be able to store and self-administer Class 1 (non-prescription medications, e.g., cold medicines, Tylenol, Advil) in the designated nurses station? **Yes** **No**

Would you like your child to be able to store and self-administer Class 2 and Class 3 (see above definition of medications) in the designated nurses station, should they be prescribed? **Yes** **No**

Do you give permission for your child to be able to transport medication from school for time away from school? **Yes** **No**

2019 -2020 Authorization for Medication

Failure to adhere to this policy is a violation of Capital City Public Charter School's Policy and will result in disciplinary action for your son/daughter.

I understand that by virtue of granting this consent, my son/daughter will be solely responsible for taking the above medication, and that Capital City Public Charter School shall have no liability whatsoever relating to the use or nonuse of the medication. I further agree that my son/daughter will store the medication in a physically secure manner while at Capital City Public Charter School and will not share the medication with any other person. I understand that at any time I may request that the medical personnel at The Health Center oversee the administration of this medication to my son/daughter. I understand that Capital City Public Charter School can revoke my son/daughter's right to self administer medications when, in the professional judgment of the Health Center's medical staff, my son/daughter has demonstrated an inability to self-medicate safely.

Signature of parent/guardian (relationship to student)

Date

I understand that I will be solely responsible for taking the above medication, and that Capital City Public Charter School shall have no liability whatsoever relating to my use or nonuse of the medication. I further agree that I will store the medication in a physically secure manner while at Capital City Public Charter School and will not share the medication with any other person. I understand that Capital City Public Charter School can revoke my right to self-administer medications when, in the professional judgment of the Health Center's medical staff, I have demonstrated an inability to self-medicate safely. I understand that failure to adhere to this policy is a violation of Capital City Public Charter School's Drug and Alcohol Policy and will result in disciplinary action.

Signature of Student (I consent to the foregoing authorization granted by my parent/guardian.)

Date