

PHYSICIAN'S AUTHORIZATION OF MEDICATION

**This form must be completed by the student's physician
before any medication can be given at school.**

NOBLE ACADEMY
3310 HORSE PEN CREEK ROAD
GREENSBORO, NC 27410
PHONE: 336-282-7044 FAX: 336-282-2048

STUDENT NAME _____ BIRTHDATE _____

MEDICATION _____ (Include trade name & prescription #)

Medication form (please circle): Tablet Capsule Liquid Inhalation Topical

Dose: _____ How often/what time: _____

Side effects (expected or predictable): _____

Relationship to meals: _____

Contraindications for Administration: _____

In order to keep this child in optimum health and to help maintain maximum school performance, it is necessary that medication be given during school hours. The parent or legal guardian knows of this request. They agree that this medication will be supplied as needed and will be delivered to Noble Academy in accordance with the school's medication policy. Should the student manifest any of the possible side effects caused by this medication, please contact the parent or physician's office.

Physician's Signature **Date**

Physician's Name (please print)

Office Phone

Drug Enforcement Administration #

PARENT PERMISSION:

I hereby give permission for my child to receive medication during school hours. I also hereby authorize Dr. _____ to fax or mail this form to Noble Academy. A licensed physician has prescribed this medication and I hereby release the Board of Trustees, the Health Room Staff, and all faculty/staff of Noble Academy from any and all liability that may result from my child taking this prescribed medication.

Parent/Guardian Signature **Date**

PLEASE RETURN THIS FORM TO THE FRONT OFFICE