



Prescription Medication Authorization
Palisades Episcopal School
13120 Grand Palisades Pkwy
Charlotte, NC 28278
704.583.1825 (Phone) 704.583.1885 (Fax)
www.pescharlotte.org

To the Parent/Guardian of: _____ **Birth date:** _____

In order to help protect your child's health, your consent and written authorization from a licensed health care provider are required when it is necessary for your Palisades Episcopal School student(s) to receive prescription medicines during school hours (including overnight field trips). A separate form is required for each medicine. New authorization forms are required at the beginning of each school year, whenever the dose or directions change, or when a new medicine is prescribed. Each medicine must be in an appropriately labeled original container from the pharmacy or health care provider's office. Most pharmacies will provide an extra container for school use upon request.

I give permission for my child to receive this medicine during school hours (including overnight field trips). I understand that it is my responsibility to purchase and supply the medication and that PES employees are acting on my behalf during school hours.

Parent Signature: _____ Date: _____

Telephone Contact Number: _____

Health Professional Section

Medication Prescribed: _____ Strength/dose: _____

Specific directions (include condition being treated by this medication, exact amount to give, at what time and/or how often, relationship to meals, specific indication if PRN, etc.):

Expected sign effects of adverse reactions:

Other instructions... Please check all that apply

- It is necessary for this student to receive this medication during school hours in order to maintain or improve health and maximize opportunities for learning.
- This medication is to be used for emergencies only.
- This student should carry this medication with him/her at all times.
- This medication may be self-administered by the student.

Signature of Health Care Provider: _____ Date: _____

Printed Name of Health Provider: _____

Practice Name: _____

Date received by Palisades Episcopal School: _____