Maureen Joy Charter School
107 S. Driver St.
Durham, NC 27703

REQUEST FOR MEDICATION TO BE GIVEN DURING SCHOOL HOURS

To be completed by Doctor/Physician:

Student Name: _____

Date of Birth: _____

Medication: _____ Dosage: _____
(School will not give any injection of medication to students)

Time(s) medication needs to be given: _____ a.m. _____ p.m.

Side Effects of Medication:

_____
_____
_____

Contraindications for administration: _____

If the student becomes sick or an emergency situation arises at school, please contact the following:

_____ Doctors office; phone # _____

_____ Take student to the nearest emergency room

_____ Other option; call parent/guardian # _____

Medication will be brought to school by parent/guardian within a proper container, labeled by pharmacist with student information (student name, medication, dosage and time given).

Physician's Signature: _____

To be completed by Parent/Guardian:

I give permission for my child (named above) to take medication during school hours. A licensed physician has prescribed the medication listed above. I hereby release Maureen Joy Charter School and employees from any/all liability that may result from my child taking prescribed medication. I do understand that the law states that school employees who administer medication at school will only be held liable for gross negligence in the performance of this duty.

Parent/Guardian Signature: _____ Date: _____

Contact Number(s): _____