Voyager Academy

Medication Authorization Form

Academic Year 2026-2027

Student's Name: _____ **Student ID #:**_____

School: _____ **Grade:** _____ **Date of Birth:** _____

Allergies: _____

PARENT AUTHORIZATION (*completed by Parent/Guardian*)

☐ I request that authorized persons at my child's school assist my child in taking the prescription or over-the-counter medication described below at the time indicated and as designated by his/her licensed prescriber.

OR

☐ I request that my child be allowed to self-carry and self-administer epipens, asthma inhalers, and/or diabetic medication. I shall hold harmless and indemnify Voyager Academy, its agents, employees, and board members against all claims, judgments, or liability arising out of self-administration and carrying of medication by my child.

For Epinephrine Auto Injector Only:

☐ I have observed my child demonstrate the necessary skill level to implement the care plan and administration of this medication prescribed by his/her health care provider.

☐ In the event my child is experiencing respiratory difficulty and is unable to administer the Epinephrine Auto Injector ordered by the physician, a trained school staff member may administer the Epinephrine Auto Injector and call 911.

I, or a responsible adult, will be responsible for bringing the prescription or over-the-counter medications to school in a labeled container from the pharmacist or the manufacturer's container. I also understand that I am responsible for maintaining enough of the medication at the school. Failure to do this will result in an interruption of the licensed prescriber's order or discontinuation of the school's administration of the medication for my child. I understand that, if my child refuses to take the medication(s) the medication(s) will not be given, and the parent will be notified. School personnel have permission to communicate with the licensed prescriber regarding use, side effects, response, and contraindications of the medication(s).

☐ I confirm that my child has previously taken this medication.

☐ My child has NOT previously taken this medication, but I have reviewed the purpose and side effects with my child.

☐ My child has NOT previously taken this medication. This is an EMERGENCY MEDICATION.

In case of emergency, please contact 1st: _____ **Phone:** _____

In case of emergency, please contact 2nd: _____ **Phone:** _____

_____ _____ _____

Signature of Parent/Legal Guardian | Relationship | Date (Month/Day/Year)

_____ _____ _____

Printed Parent Name | Telephone | Email

LICENSED PRESCRIBER AUTHORIZATION (*to be completed by the Healthcare Provider*). *I am prescribing the following medication for the above student to be administered at school*

PRESCRIPTION MEDICATION ☐ DAILY ☐ PRN

Name of Medication *(Generic and Trade name)*: _____

Purpose of Medication: _____

Start Date: _____ End Date: _____

Form: ☐ Tablet/Capsule ☐ Inhalation ☐ Liquid ☐ Ointment ☐ Injection ☐ Other: _____

Dose: _____ Route (PO, IV, SC, GT): _____ Frequency of Dosage: _____

Specific Time Medication is to be administered at school: _____

Specify side effects or adverse reactions: _____

_____

Other instructions (including emergency situations): _____

_____

OVER THE COUNTER MEDICATION ☐ DAILY ☐ PRN

Name of Medication *(Generic and Trade name)*: _____

Purpose of Medication: _____

Start Date: _____ End Date: _____

Form: ☐ Tablet/Capsule ☐ Inhalation ☐ Liquid ☐ Ointment ☐ Injection ☐ Other: _____

Dose: _____ Route (PO, IV, SC, GT): _____ Frequency of Dosage: _____

Specific Time Medication is to be administered at school: _____

Specify side effects or adverse reactions: _____

_____

Other instructions (including emergency situations): _____

_____

The above orders shall be effective throughout the current school year, unless the orders are discontinued, changed or withdrawn in writing by the parent before that time elapses.

_____ _____
Licensed Prescriber's Signature Date

_____
Printed Prescriber's Name

_____
Phone

Clinic Stamp

SCHOOL MEDICATION ADMINISTRATION POLICY AND GUIDELINES

DEFINITION OF MEDICATIONS:

Medication is defined as any oral, topical, inhaled, or injected mediation (whether prescribed or over-the-counter) that may be administered in compliance with the medication policy and procedures. Over-the-counter medication includes: aspirin, acetaminophen, ibuprofen, herbs, vitamins, minerals, sprays, creams, and ointments. At Voyager Academy, over-the-counter medications can only be administered through a doctor's order.

ADMINISTRATION OF MEDICATION:

Whenever possible, medication should be administered at home. If a medication is required to be administered by school personnel, the Voyager Academy Medication Authorization Form MUST be completed and signed by the prescribing physician and the parent. Prescription medication MUST be in the most current pharmacy labeled container. Over-the-counter medication MUST be provided in the original container, with dosage and side effects listed. The student's name, date of birth, and grade should be labeled on the medication by the parent/guardian. A new Medication Authorization Form must be completed each school year AND/OR anytime the dose or instructions change.
A separate Authorization Form for EACH medication is required.

OTHER CRITERIA FOR APPROVAL OF MEDICATION USAGE AT SCHOOL:

- Required to maintain and support the child's continued presence at school.
- Required to maximize the child's classroom performance.
- FDA approved for the school setting.
- Deemed safe for use in the school setting.

PLEASE AVOID requesting school administration of medications that can normally be given outside school hours, such as antibiotics, over the counter pain relief medication, and allergy medications. Administration may use their judgment in deeming if medically necessary medication can be given outside normal school hours.

SELF-ADMINISTRATION OF MEDICATIONS:

Asthma inhalers, epi-pens, and diabetic supplies may be carried and self-administered according to the North Carolina State law.

EXTRACURRICULAR ACTIVITIES/OUTSIDE SCHOOL HOURS ACTIVITIES:

Student medications stored on campus for regular school hours are locked and secured at the end of each school day and will not be available during extracurricular/after school hours activities. Parents of students that may require or need access to medications such as diabetic medications, Epipens, oral antihistamines, nasal rescue sprays, or inhalers after regular school hours should communicate directly with the coach, teacher or program director AND consider having their student self-carry medications in their bookbag.

Last updated: 5/1/26