Mitchell Road
CHRISTIAN ACADEMY

AUTHORIZATION FOR PRESCRIPTION MEDICATION AT SCHOOL

PLEASE PRINT School Year_____

STUDENT'S NAME_____ Homebase Teacher _____

NAME OF MEDICATION_____

REASON FOR GIVING MEDICATION AT SCHOOL (Please be specific)

_____

DOSAGE/AMOUNT OF MEDICATION TO BE GIVEN_____

TIME OF DAY MEDICATION IS TO BE GIVEN AT SCHOOL_____

DATE TO START MEDICATION _____ DATE TO STOP MEDICATION_____

EXPIRATION DATE OF MEDICATION _____

POSSIBLE SIDE EFFECTS_____

PHYSICIAN PRESCRIBING_____

PHYSICIAN'S PHONE # _____

Parents Please Read Carefully:

I understand that all medication will be provided by me in the original container, clearly labeled with my child's name. I will notify the school if the medication is discontinued or the dosage has been changed. Permission is granted to the principal and/or school nurse to share this information with individuals who have responsibility for my child. The first dose will be given at home so that I can monitor adverse reactions. I give the school nurse my permission to contact the above physician's office to request medical information concerning my child. I am responsible for replacing medication before the expiration date. Expired medication will not be given at school.

PLEASE PRINT PARENT/LEGAL GUARDIAN NAME_____

PARENT/LEGAL GUARDIAN SIGNATURE _____DATE _____

PLEASE NOTE:

A SEPARATE PERMISSION FORM IS REQUIRED FOR EACH MEDICATION TO BE GIVEN.

PLEASE PICK UP ALL MEDICATIONS PRIOR TO THE LAST DAY OF SCHOOL. ANY MEDICATION NOT PICKED UP WILL BE DESTROYED.

ALL MEDICATIONS MUST BE HAND DELIVERED BY AN ADULT TO THE SCHOOL NURSE OR MAIN RECEPTIONIST IF THE NURSE IS NOT AVAILABLE.