<u>AUTHORIZATION FOR ADMINISTRATION "OVER THE COUNTER MEDICATION" AND/OR PRESCRIPTION MEDICATIONS AT PORTLAND CHRISTIAN ELEMENTARY SCHOOL</u>

Student
Name________________________________Birthdate__________Age________Grade_______________

Name of Medication____

Dosage____

Time to be Taken__________________________________ Length to be Taken______________________

Reason for Medication to be given during school hours____

____

Emergency Procedures in case of serious side effects____

____

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student. I request and authorize the school to administer the above identified medication to the above identified student in accordance with my instructions for the period

beginning the _______day __________,________through the _______day of__________,________
(NOT TO EXCEED ONE SCHOOL YEAR)

____
(**Parent/Guardian's Signature**)

MEDICATION MUST BE SUPPLIED TO THE SCHOOL IN THE **<u>ORIGINAL</u>** CONTAINER

PRESCRIPTION MEDICATIONS DO NOT NEED A DOCTORS SIGNATURE ON THIS FORM AS LONG AS THE FOLLOWING INFORMATION IS ON THE PHARMACY LABEL:

- Name of student
- Name of medication
- Route of administration
- Dosage and frequency of administration
- Any special instructions

*After Medication is Discontinued, Place this form in the Students Cumulative File