GRACE CHRISTIAN ACADEMY

Authorization for Administration of
Prescription Medication

Prescription medications that Parent/Guardian request to be administered to student must be in pharmacy-prepared containers and labeled with the name of the student, name of medication, strength, dosage, frequency, name of Medical Provider (physician, dentist, APRN, or PA) and date of original prescription.

Name of Student_____Date_____

Address_____DOB_____

Condition for which the medication is needed to be administered while at school_____

_____

Drug (name, dose, and method of administration)_____

_____

Time of Administration: _____

Medication shall be administered from_____ to_____

Side effects to be observed, if any_____

If there are side effects, plan for management_____

Medical Provider's signature_____

Authorization by Parent/Guardian for administration of the above medication to be given by School Personnel:

I request that the above medication, ordered by the medical provider for my child, _____, be administered by School nurse or School personnel. I understand that I must supply the school with the prescribed medication in the original container, dispensed and properly labeled by provider or pharmacist, and will provide no more than a 45 school day supply. I understand that this medication will be destroyed if it is not picked up within one week following the termination of the order or one week following the close of the school year.

Name_____

Signature_____ Relationship to Student_____

Phone_____ Date_____