Mitchell Road
CHRISTIAN ACADEMY

AUTHORIZATION FOR PRESCRIPTION MEDICATION AT SCHOOL

- Please complete a separate form for each medication.
- Medications must be hand delivered by an adult to the school nurse or main receptionist if the nurse is not available.
- Medications will not be administered without this completed form including required signatures.

THIS SECTION MUST BE FILLED OUT BY A LICENSED HEALTH CARE PROVIDER	
Student's Legal Name	Date of Birth:
List Allergies:	
Prescribed Medication:	Dose: Route:
Time of day for administration at school: (specific time i.e. 8am, eakfast", or "lunchtime")	Reason for Medication at School:
Date to Start Medication:	Stop Medication:
Possible Side Effects:	
Licensed Health Care Provider Name: Office Address:	Phone: Fax:
Licensed Health Care Provider's Signature:	Date:
PARENTS/LEGAL GUARDIANS PLEASE READ AND SIGN BELOW	

- I understand that all prescribed medications must be 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.
- I give permission for the principal and/or school nurse(s) to share this information with individuals who have responsibility for my child.
- The first dose of any new medication will be given at home so that I can monitor adverse reactions.
- I give the school nurse(s) 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.
- Medications must be picked up prior to the last day of school. Any medications not picked up will be destroyed.
- Date Medication Expires:_____

Parent/Legal Guardian Signature_____ Date:_____
Parent/Legal Guardian Printed Name_____