BELLEVUE CHRISTIAN SCHOOL - CLYDE HILL CAMPUS
AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student Name: _____ | Date Med Rec'd _____Date Exp. Logged _____

Birthdate: _____ Teacher: _____ Grade: _____

Parent Name: _____Phone: (hm) _____ (wk)_____

THIS PORTION TO BE COMPLETED BY THE PHYSICIAN FOR PRESCRIPTION MEDS OR TO BY PARENT/GUARDIAN FOR OVER-THE-COUNTER MEDS

(A SEPARATE FORM MUST BE COMPLETED FOR EACH DIFFERENT MEDICATION)

MEDICATION	DOSAGE	METHOD OF ADMINISTRATION	TIME OF DAY TO BE TAKEN
_____	_____	_____	_____

DATES TO BE ADMINISTERED: From _____day of _____ , through the _____ day of _____

Reason for medication to be given during school hours: _____

Potential symptoms that indicate medication is advised: _____

_____

Possible side effects of medication: _____

_____

Emergency procedure in case of serious side effects: _____

I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated on this form. There exists a valid health reason which makes administration of this medication(s) advisable during school hours or during such time that the student is under the supervision of school officials. Such medication may be administered by medically untrained school personnel.

Physican Signature: _____ Date: _____

Physician Name (type or print): _____

Address: _____ Phone: _____

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I certify that I am the parent/legal guardian of the above identified student and request and authorize the school to administer the above identified medication to the above identified student in accordance with the above instructions for the period beginning the _____day of _____, through the _____ day of _____ (not to exceed one school year).

MEDICATION MUST BE SUPPLIED TO THE SCHOOL IN THE ORIGINAL CONTAINER

Parent/Guardian Signature: _____ Date: _____

BCS Office Fax#: 425-454-4418 **Rev. 5/11/21**