Providence
CHRISTIAN SCHOOL of TEXAS

Medical Authorization Form

Administration of Medicine or Special Procedure by School Personnel

School personnel may administer special health care procedures and medications at school or on an off-campus trip when such treatment is necessary for attendance and cannot otherwise be accomplished. **This completed form along with the medication and/or special equipment items must be brought to the school by the parent.** The medication must be brought to school in the original container appropriately labeled by the pharmacy and stay at school for the duration of administration. Non-prescription medication must be in the original container, labeled with the student's name, the dosage, and the time the medication is to be administered by the pharmacy.

Date of Request: _____ **Student Name:** _____ **Grade:** _____

Medication: _____ **Dosage:** _____

Frequency: _____ **Dates of Administration:** _____

Condition for which prescribed treatment is required: _____

Precautions, unfavorable reactions: _____

Physician's Name: _____ **Telephone Number:** _____

STUDENT SELF-CARRY/SELF-ADMINISTRATION MEDICATION

Prescribed asthma inhaler and Epi-Pens may be kept by the student and self-administered. School Personnel must be informed of and grant authorization to all students who need to self-administer medication for asthma, severe allergic reaction, or diabetes. Written Order by physician, Medication Authorization Form, an Allergy/Procedure Action Plan, and School Nurse approval are required.

I, the undersigned, the parent/guardian of _____, request the above medication be administered to my child. I hereby waive and release Providence Christian School of Texas, its Trustees, Head of School, Faculty, Staff, school nurse, agents, employees, volunteers and invitees, including parents of students assisting with any trip or activity, from any and all claims, injuries, suits, loses, damages, causes of action or other liabilities which may arise in connection with the administration or lack of administration of the foregoing medication(s).

Parent/Guardian Signature: _____ **Phone:** _____

Physician Signature: _____ **Physician Phone:** _____

Physician Address: _____