Grove City Christian School
Prescribed Medication Authorization

Purpose: To permit students to possess and use medications during school hours when regular attendance at school would be impossible without the medications.

Name _____ Date of birth _____

Address _____ Telephone _____

City, State, Zip _____

To the Parent or Guardian:

The following information is necessary for any student who possesses or uses prescribed medications in school. Both portions of this must be completed.

1. I am requesting permission for the student named above to possess and use medications according to the doctor's verification on this card.
2. I will assume responsibility for the safe delivery of the medications to school, either by myself or by the student.
3. I will submit a revised statement to school immediately if there is any change in the use of the medication.
4. I release and agree to hold Grove City Christian School, its officials and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

_____ _____

Signature or Parent or Guardian Date

_____ _____ _____

Home Telephone Cell Telephone Work Telephone

Physician Statement

To the Physician:

Grove City Christian School urges you to schedule the administration of medications by students at times outside of school hours. When this is not possible, the possession and use of medications will be permitted, insofar as feasible, during school hours. Medication in pill form is preferable to liquids for use in school.

I verify that this medication must be taken by _____ during school hours: _____
(Student name)

_____ _____ _____

(medication) (dosage) (route)

Medication is to be taken at the following times: _____ _____ _____ _____

Instructions or precautions (including possible side effects that should be reported to the physician):

_____

Beginning Date: _____ Expiration Date: _____

Physicians : _____
(Signature) (Date)

Physicians Printed Name: _____ Telephone # _____

Address _____