MARANATHA
CHRISTIAN ACADEMY

Rx Medication Form

Permission to administer PRESCRIPTION medications during school attendance

COMPLETED by **HEALTH CARE PROVIDER**:

Student: _____ Grade: _____

Medication:_____ Dosage:_____ Date of Initial Dosage:_____

Reason for Rx:_____

Instructions for Administration: _____

Time of day Rx to be given: ☐After Lunch ☐As Needed ☐Other Time:_____

Anticipated duration of Rx at school: ☐ School Year ☐Other:_____

PRINTED name of prescribing physician: _____

_____

Health Care Provider Signature (REQUIRED) **Date**

COMPLETED by **PARENT / GUARDIAN**

Checklist must be complete!

- ☐ Primary Care Provider section fully completed
- ☐ Prescription Medication is:
  - ☐ In the ORIGINAL container
  - ☐ MUST CONTAIN A PHARMACY LABEL with:
    - ✓ Name of student
    - ✓ Name of medication
    - ✓ Dose & time to be administered
    - ✓ Number of days to be administered
    - ✓ Current prescription date
- ☐ If student will carry & self-administer medication for the treatment of anaphylaxis or asthma (ex: inhaler, Epi-Pen, Auvi-Q) the form ***Permission for Self-Administration of Medication*** must **ALSO** be completed and signed by the Health Care Provider

I understand that any school employee who administers any of the above medications, in accordance with the prescription and/or over the counter directions, to my student shall not be liable for damages as a result of an adverse reaction suffered by the student due to this administration. I further acknowledge that the above student has taken the medication(s) previously (or the initial dosage) and has experienced no adverse reactions

_____

Parent/Guardian Signature (Required) **Date**