



MEDICATION PERMISSION FORM

Medication will be administered to students during school hours when such medication is needed by the student to remain in school and administration is required during school hours. No medication will be administered to any student without proper completion of the Medication Permission Form.

All medication to be administered by school personnel must be delivered by an adult to the Health Office in the original, properly labeled container. Prescription medication will be locked in the nurse's office. In accordance with state law, medications can only be returned to a parent or legal guardian. Students are not permitted to carry any medication with them in school. Exception: Properly labeled inhalers, diabetic supplies, and Epi-pens may be self-carried with physician approval and the "Self-Carry Administration Form".

TO BE COMPLETED BY PHYSICIAN / DENTIST

Student's Name: _____ Age _____ Grade: _____ DOB: _____

Name of Medication: _____

Specific Dosage: _____ Frequency: _____

Special Considerations: _____

Reason for Medication: _____

Effective Date—From: _____ To: _____ (limit of one school year)

It is my understanding that the employees of Faith Christian Academy charged with the administration of this treatment/procedure during school hours rely on the directions contained in this document. I further certify that I am the physician or dentist who prescribed the medication/ treatment and that the student named above is under my supervision as a patient.

Signature of Physician/Dentist: _____

Printed Name of Physician/Dentist: _____

Telephone: _____ Fax: _____ Today's Date: _____

TO BE COMPLETED BY PARENT / GUARDIAN: As parent/guardian of the above-named student, I hereby request that the treatment described above be administered to my child. I release Faith Christian Academy and its employees from liability for any damages my child may suffer as a result of this request.

Signature of Parent or Guardian: _____