

# FIRST BAPTIST CHRISTIAN SCHOOL

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## PARENT/GUARDIAN AUTHORIZATION TO GIVE MEDICATION AT SCHOOL

If medication can be given at home or after school hours, please do so. However, if medication must be given during school hours, this form must be completed. Please write one medication per page.

Student's Name: \_\_\_\_\_

Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_

I request that \_\_\_\_\_ School; through the principal or designee supervise/assist in the administering of medication to my child, according to the instructions below. I understand that:

- Medications must be in the original labeled container (no baggies, foil, etc.). Pharmacists can provide a duplicate labeled container with only the school doses.
- Parent/guardian must provide specific instructions, as well as the medication and related equipment to the principal or school office personnel.
- It will be the responsibility of the parent/guardian to inform the school of any changes. New medication or new doses will not be given unless a new form is completed and a newly labeled container is provided.
- All medication will be taken directly to the office/school office by the parent.
- Unused medication will be disposed of unless picked up within one week after medication is discontinued.

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Name of Medication: \_\_\_\_\_

Dose: \_\_\_\_\_ Route (by mouth, topical, etc): \_\_\_\_\_

Time(s) to be given: \_\_\_\_\_ Stop Medication on: \_\_\_\_\_

Condition/Illness Requiring Medication: \_\_\_\_\_

Possible Side Effects, if any: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Physician's Phone: \_\_\_\_\_

I hereby authorize the personnel, employees and officials of the \_\_\_\_\_ School District to assist my child in taking prescribed medication according to district policy and I release them from any liability for administering this medication. I understand that, in the event of a change in medicine, I am responsible for presenting a new request form.

\_\_\_\_\_  
**Parent/ Legal Guardian signature** \_\_\_\_\_  
**Date**

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Pager/Cell Phone \_\_\_\_\_

*To be completed by School Health School office Personnel only:*

Date received: \_\_\_\_\_ Name of Medication: \_\_\_\_\_ # Doses: \_\_\_\_\_