AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT PORTLAND CHRISTIAN JR/SR HIGH SCHOOL

Student Name: **Date of Birth:** **Grade:**

_____

Name of Medication	Dosage	Method of Administration	Time of Day to be Taken

_____

Reason for medication to be given at school:

_____

Anticipated Action: _____

Possible Side Effects: _____

Emergency procedure in case of serious side effects: _____

_____

I request and authorize that the above named student be administered the above identified medication in accordance with the instructions for the period indicated below:

Beginning _____/_____/_____

Ending _____/_____/_____

I certify that I am the parent/legal guardian, or other person in legal control of the above identified student. I request and authorize the school to administer the above identified medication to the above identified student in accordance with the prescription or doctor's instruction for the above period of time.

MEDICATION MUST BE SUPPLIED TO THE SCHOOL IN THE ORIGINAL CONTAINER

Parent or guardian signature:_____ **Date:**_____

Phone: _____ Work:_____ Cell:_____

NOTE: After medication discontinuance, place this form in Student's cumulative file

HEALTH ROOM RECORD
MEDICATION FORM

_____

STUDENT NAME

STUDENT SIGNATURE	DATE	TIME	MEDICATION GIVEN	STAFF SIGNATURE

COMMENTS: _____

_____

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