Medication Authorization

to access and use prescribed medications during school
ONE FORM PER MEDICATION

Student Name_____ Date of Birth_____ School Year_____

Home Address_____ School Calumet Christian HR/Grade _____

Healthcare Provider to Complete:

I verify the above student should receive this medication at school for treatment of_____

Medication_____ Dosage_____
Route_____

Administration Time(s)_____ Beginning Date _____ Expiration Date_____ /end of school year

Instructions, precautions, and possible side effects_____

_____

Other medications prescribed to this student (home & school) _____

_____

Healthcare Provider Signature_____ **Date**

Please fill contact information to left or stamp here

Provider Name _____

Practice Address_____

_____

Parent to Complete:

Parent/Guardian Name_____ **Phone Numbers** _____ **or** _____

To the Parent or Guardian: The following information is necessary for any student who uses medication in school.

- **Both the parent and healthcare provider portions of this form must be completed**.
- A new Medication Authorization form is required each school year and when there is a change in the medication.

- I authorize the student named above to have access to and use the medication as ordered above.
- I understand the medication must be in the original container and properly labeled with student's name, date, prescriber's name, name of medication, dosage, strength, route and time of administration and drug expiration date.
- I assume responsibility for the safe delivery of the medication to school and will notify the school immediately with any medication changes.
- I authorize the school nurse to communicate with the student's healthcare provider about the medication as needed.
- I release and agree to hold Xenos Christian Schools, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

Parent/Guardian Signature _____ **Date**_____