Summit Christian Academy

AUTHORIZATION TO DISPENSE MEDICATION

All medications must be brought directly to the nurse by the parent or guardian with this completed form.

NEVER send medication with the student.

MEDICATION MUST be in the ORIGINAL CONTAINER with the STUDENT'S NAME

Date _____________

Student ____ Grade _________________

Medication:________________ Dosage: _____Time_________Reason:___________________ Exp:_____
Medication:________________ Dosage: _____Time_________Reason:___________________ Exp:_____
Medication:________________ Dosage: _____Time_________Reason:___________________ Exp :____
Medication:________________ Dosage: _____Time_________Reason:___________________ Exp:_____

Parent or Guardian's Signature_____________________________ Phone #_____________

For Asthma or Diabetes:
I authorize my child to self-administer & carry his/her prescription asthma or diabetes medication while on school property or at school-related events. **YES** **NO**

Parent or Guardian's Signature___________________________ Phone # ____________

A licensed health care provider must complete the following:

This student has asthma or diabetes and is capable of self-administering the prescription medicine.
YES **NO**
Name of medication ______________________________ Dosage ____________________
Circumstances under which the medicine may be administered _________________________

Health Care Provider's Signature________________________ Phone #____________ Date __________

For Narcotic Medication only:
A licensed health care provider **MUST** complete the following if a narcotic medication is required to be administered at school.
Name of medication __________________________ Dosage ___________________
Circumstances under which the medicine may be administered ___________________________

Licensed Health Care Provider's Signature ____
Phone # __________________ Date____________________

If a student requires a narcotic for pain, they should not be at school. An appropriate dose of pain control should cause drowsiness affecting the student's ability to learn. Special arrangements will be considered for long term health issues with appropriate documentation from a physician.

Updated 10/25/17

Please Document Medications Here

Student’s Name____Grade________________

Medication:____
Medication:____
Medication:____

Date	Time	Medication	Dosage	Reason	Staff Initials	Parent Notified

Updated 10/25/17