



CHRISTIAN HERITAGE SCHOOL

AUTHORIZATION FOR ADMINISTRATION OF PRESCRIPTION ORAL MEDICATION AT SCHOOL

Student Name: _____ Birth Date: _____

Teacher: _____ Grade: _____

THIS PORTION TO BE COMPLETED BY PHYSICIAN

Name of Medication	Dosage	Methods of Administration	Time of Day To Be Taken

If given as needed, specify the length of time between doses: _____

Inhalers: _____

Indicate if student must carry on his/her person

Possible side effects of medication: _____

I request and authorize that the above named student be administered the above-identified oral medication in accordance with the instructions indicated above from _____ to _____ (not to exceed current school year) as there exists a valid health reason which makes administration of the medication advisable during school hours.

Date of Signature

Physician Signature

Telephone Number: _____ Name: _____
(Print or Type)

Please note: If samples of medication are to be given, they must be labeled with the name of the student, dosage, and time to be given.

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I request/authorize the school to administer medication to the above identified student in accordance with the doctor's instructions for the period from _____ to _____ (not to exceed the current school year). I understand that every effort will be made by school staff to administer the medication in a timely manner.

Permission to carry inhaler: _____ Yes _____ No

Date of Signature

Parent/Guardian Signature

Telephone Number: (Home) _____ (Work) _____