CHRISTIAN LIFE ACADEMY

PERMISSION for ADMINISTRATION of OVER- the-COUNTER MEDICATION

(To be completed by parent of guardian only)

Student name: ___________________________ Date form received: _______

Teacher: _____________________________ Grade: _________ Date of birth: ________________

Name of medication: _____________ Dosage: _________ Frequency: ______________________

Reason for medication: ____

Medication form: (   ) Tablet/Capsule (   ) Liquid (   ) Inhaler (   )Nebulizer (   ) Other
____

Instruction schedule and doses to be given while at school: ________________________________

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All medication must be kept in the office, in its original container with a copy of these instructions. The original form will be placed in the student's health file.

My child is both capable and responsible for self - administration of this medication:
(   ) NO (   ) YES, supervised (   )YES, unsupervised

I give permission for (name of child) ____

to receive the above medication at school according to school policy.

Date: ________________ Signature: ____________________________________

Relationship to child: ______________________________ Telephone: _________________