CHRISTIAN LIFE ACADEMY

Permission for Administration of Prescribed Medications

FAX # (814) 676 - 2908

Student name:_____ Date form received: _____

Teacher: _____ Grade: _____ Date of birth: _____

To be completed by the physician or authorized prescriber

Medication: _____ Dosage: _____ Frequency: _____

Duration: Start: ( ) date form received ( ) Other date
_____

Stop: ( ) end of school year ( ) Other date
_____

( ) for episodic / emergency events only _____

Instructions (schedule and doses to be given while in school) :
_____

_____

Medication /treatment form: ( ) tablet ( ) capsule ( ) liquid ( ) inhaler ( ) injection ( ) nebulizer ( ) other: _____

Special storage requirements: ( ) none ( ) refrigerate ( ) other
_____

Restrictions and / or side effects: ( ) none anticipated ( ) yes, please describe
_____

This student is both capable and responsible for self - administering this medication:
( ) NO ( ) YES, supervised ( ) YES, unsupervised

Please indicate if you have provided additional information: ( ) YES ( ) NO

Physician's name: _____

Address: _____Phone : _____

Physician Signature: _____

To be completed by parent / guardian: I give permission for (student) _____ to receive the above medication at school according to school policy.

Date: _____ Signature: _____

Relationship: _____

All parent / guardians are to bring medications to school office in original containers.