Northside Christian Academy

Prescription and Nonprescription Medication/Treatment Authorization Form

Before any Medication/ treatment can be given the following must be completed and received by the Nurse.
Over the Counter medication can be approved by parents' signatures.

Prescription ❒ ***Over the Counter*** ❒

Student's Name: ________________________________ **School/Class:** ______________________________

Medication and/or Treatment Name: ____

Strength of Medication: ____

Dosage, Route, and Time to be Administered: ____

Special Instructions for Medication Administration: ____

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Reason for Medication/Treatment: ____

Administration Start Date: ____________________ Administration End Date: ____________________

Possible Adverse Reaction to report to Physician ____

If Applicable

This student received instruction in the use of the above inhaler by my trained staff or me.
I recommend that this student carry his/her inhaler on his/her person at all times. ***Yes No***

This student received instruction in the use of the above EpiPen by my trained staff or me.
I recommend that this student carry his/her EpiPen on his/her person at all times. ***Yes No***

Name of Physician: ____ Phone: ______________________________

Signature of Physician: ____ Date: _______________________________

I hereby request and give permission to the nurse, principal, or the principal's designee to administer the prescribed medication listed above to my child as instructed by the physician or authorized healthcare provider with prescriptive authority. My child has taken this medication under my supervision and has had no negative side effects. If applicable, my child may carry his/her inhaler or EpiPen as prescribed by a physician on his/her person during school or school-related activities as stated above. My child and I are aware of the protocols and safety issues at school.

All medication must be clearly labeled and brought to the school (by the parent or guardian) in the original container as dispensed by the authorized healthcare provider, physician, or pharmacist. Ask the pharmacist to give you two containers if necessary. Send only the amount of medication that will be administered during school hours or school-sponsored activities. Medications will be kept in the school clinic/office or another secure storage area.

If any revisions to the above plan or prescriber's statement occur, a written revised prescriber's statement must be submitted to the nurse, principal, or the principal's designee. It is understood that it is the student's responsibility to seek the medication at the proper location and time unless s/he is physically or mentally unable to do so. I release and agree to hold the school and its designees harmless from any all liability or injury resulting directly/indirectly from this authorization.

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Signature of Parent/Guardian Phone (Home/Work/Cell)

Date Received at School: ____________________________ Initials: ___________