

# Authorization to Give Medication

**Student Name:** \_\_\_\_\_ **Grade :** \_\_\_\_\_

Complete this form if your child will be taking medication during a school day, activity or field trip.

I hereby request that the Fellowship Christian School System, through designee, will supervise/assist in the administration of medication to my child according to the instructions provided on the statement below. I understand that:

- Medications must be in original labeled container (no baggies, foil, etc.)
- Parent/guardian must provide signed form, specific instructions, and medication with related equipment to the school nurse or clinic personnel. Parent must personally deliver to clinic personnel.
- All prescription medication must have the prescription label on the container
- Unused medication will be disposed of unless picked up within one week after medication is discontinued.
- Only middle/high school students have the option of keeping their inhaler/epipen with them

**Name of medication :** \_\_\_\_\_  
(Include inhalers and epipens)

Reason for medication : \_\_\_\_\_

Dosage and time to be given : \_\_\_\_\_

Special instructions/concerns : \_\_\_\_\_

Physician's name : \_\_\_\_\_ Phone : \_\_\_\_\_

Location(s) of epipen/inhaler : \_\_\_\_\_

**Name of medication :** \_\_\_\_\_  
(Include inhalers and epipens)

Reason for medication : \_\_\_\_\_

Dosage and time to be given : \_\_\_\_\_

Special instructions/concerns : \_\_\_\_\_

Physician's name : \_\_\_\_\_ Phone : \_\_\_\_\_

Location(s) of epipen/inhaler : \_\_\_\_\_

I release the school board, the school, school employees and/or any designated volunteer from any liability for administering this medication.

Parent/Guardian Signature \_\_\_\_\_ Name Printed \_\_\_\_\_

Date \_\_\_\_\_ Phone \_\_\_\_\_