

**FIRST BAPTIST CHRISTIAN SCHOOL**

**AUTHORIZATION TO GIVE MEDICATION AT SCHOOL**

**If medication can be given at home or after school hours, please do so. However, if medication must be given during school hours, this form must be completed.**

**STUDENT'S NAME:** \_\_\_\_\_

**TEACHER:** \_\_\_\_\_ **GRADE:** \_\_\_\_\_

I hereby request that the \_\_\_\_\_ School, through the principal or designee, supervise/assist in the administering of medication to my child, according to the instructions contained on the statement below. I understand that:

- Medications must be in the original labeled container (no baggies, foil, etc.).
- Parent/guardian must provide specific instructions, as well as the medication and related equipment to the principal or clinic personnel.
- It will be the responsibility of the parent/guardian to inform the school of any changes. New medication or new doses will not be given unless a new form is completed and a newly labeled bottle is provided.
- All medication will be taken directly to the office/clinic by the parent/ guardian.
- Unused medication will be disposed of unless picked up within one week after medication is discontinued.

\*\*\*\*\*

**Name of Medication:** \_\_\_\_\_

**Time(s) to be given:** \_\_\_\_\_ **Dose:** \_\_\_\_\_ **Route:** \_\_\_\_\_

**Stop Medication On:** \_\_\_\_\_

**Healthcare Provider's Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

I release the school board, the school, and any school employee from any liability for administering this medication.

\_\_\_\_\_  
**Parent/Legal Guardian Signature** **Date**

**Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_ **Pager/Cell Phone:** \_\_\_\_\_

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**To be completed by healthcare provider for all medications required for two weeks or more.**

**Condition/Illness Requiring Medication:** \_\_\_\_\_

**Possible Side Effects, if any:** \_\_\_\_\_

\_\_\_\_\_  
**Signature of Healthcare Provider** **Date**