AUTHORIZATION OF MEDICATION FOR STUDENTS

Student's name____**Birthdate**_______________________

In order to keep this child in optimum health and to help maintain maximum school performance, it is necessary that medication be given during school hours.

Medication Name:

Prescription____

Dosage amount to be given____

Relationship to meals____

How often and at what time____

Side effects (expected and predictable)____

Non Prescription____

Dosage amount to be given____

Relationship to meals____

How often and at what time____

Side effects (expected and predictable)____

No injection will be given except in extreme emergency, such as allergy to wasp or bee sting.

Child's parent/guardian knows of this request and is in full agreement that this medication will be supplied as directed. Should the student manifest any of the following symptoms caused by the medication, please contact the patent or my office.

Contraindications for administrations____

Parent's Permission

I hereby give my permission for my child (named above) to receive medication during school hours. On behalf of my child I absolve the Covenant Day School and its Board of Directors and their agents and employees from any and all liability whatsoever that may result from my child taking this medication.

_________________________________ _________________ ______________________

Signature of Parent or Guardian (required for prescription and non prescription) — Date — Telephone Number

Covenant Day School
Medication Sign-In Sheet

Name	Date	Time	Medication	Amount	Given By

Rev 07-08