

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 parent 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