MEDICATION ADMINISTRATION CONSENT FORM
GRACE CHRISTIAN SCHOOL
To Be Completed by Parent or Guardian

NAME OF STUDENT: ____ GRADE: ________

NAME OF MEDICATION: ____

DOSAGE (amount to be giving at school):____

REASON FOR MEDICATION:____

TIME (to be taken at school):____

DATE BEGINNING MEDICATION: ________________DATE ENDING MEDICATION:_______________________

EXPIRATION OF MEDICATION: ____

PRESCRIBING PHYSICIAN'S NAME: ____
(For Prescription Medication Only)

PARENT CONTACT NUMBER(S): ____

PARENT/GUARDIAN PERMISSION

I am the parent/guardian of _______________________________________. I give my permission and request that designated school personnel administer the above medication at the times and date indicated above. I agree to furnish prescription medication in the original container with the label intact. I agree to furnish non prescription (over the counter) medication in the original unopened container. I understand and accept that the Grace Christian School Board, its employees, agents, or designees are not responsible for any effect of the medication administered.
Medications may not be sent in w/student

____ ________________________
Parent/Guardian Signature Date

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SELF-ADMINISTERED and POSSESSION OF MEDICATIONS FOR ASTHMATIC/DIABETIC/SEVERE ALLERGY <u>ONLY</u>

For Epipens, Inhalers, and/or Insulin injections ONLY.
I request and provide physician authorization that my child self-administer the above medication. I verify he/she is capable and responsible for self-administering the medication:

____ With Assistance ____ Without Assistance

____ ________________________
Parent/Guardian Signature Date

Epipen, Inhaler, and/or Insulin injections ONLY. I request and provide physician authorization that my child have possession of the above. I verify he/she is capable and responsible for having possession of this medication:

____ ________________________
Parent/Guardian Signature Date

************************************END OF YEAR PICK UP***************************************

ANY MEDICATION NOT PICKED UP BY THE LAST DAY OF SCHOOL WILL BE DISCARDED BY CLINIC PERSONNEL

PICKED UP BY: ____DATE:_____________________