



HARVEST CHRISTIAN ACADEMY

MEDICATION ADMINISTRATION

I, THE PARENT/GUARDIAN OF : _____ REQUEST THAT SCHOOL STAFF GIVE THE FOLLOWING MEDICATION _____ TO MY CHILD, ACCORDING TO THE HEALTH CARE PROVIDER'S SIGNED INSTRUCTIONS ON THE LOWER PART OF THIS FORM.

Harvest Christian Academy agrees to administer medication prescribed by a licensed health care provider. It is the parent/guardian's responsibility to furnish the medication. The parent/guardian agrees to pick up expired or unused medication within one week of notification by staff.

Prescription Medications must come in a container labeled with: Child's name, name of medicine, time medicine is to be given, dosage, date medicine is to be stopped, and licensed health care provider's name. Pharmacy name and phone number must also be included on the label. Over-the-counter medication must be labeled with child's name. Dosage must match the signed health care provider's authorization, and medicine must be packaged in original container.

By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the nurse or school staff delegated to administer medication.

Parent/Legal Guardian's Name

Parent/Legal Guardian Signature

Date

Health Care Provider Authorization to Administer Medication in School

Child's Name: _____ Date of Birth: _____

Medication: _____

Dosage: _____

Route of Administration: _____

Time(s) to be given: _____

Purpose of Medication: _____

Possible side effects requiring notification: _____

Starting Date: _____ Ending Date: _____

Signature of Health Care Provider with Prescriptive Authority

License Number of Health Care Provider

Printed Name of Health Care Provider

Phone Number

**PLEASE REQUEST PHARMACIST FOR A SEPARATE BOTTLE/CONTAINER TO KEEP AT SCHOOL.
(Continued on Reverse)**