MEDICATION AUTHORIZATION FOR STUDENTS

School: Providence United Methodist Church Weekday School

Telephone: 704-714-9373 Fax: 704-365-6800

Child's Name ____ **Birthdate** __________________

In order to help protect your child's health, your consent and written authorization from a licensed healthcare provider are required when it is necessary for you child to receive prescription and non-prescription medicines in Providence United Methodist Church Weekday School. Medications cannot be given to your child at school until this authorization has been received. A separate form is required for each medicine. New authorization forms are required every year at the beginning of school, whenever the dose or directions change, or when a new medicine is prescribed. It is your responsibility to provide all medicines to be given at school. Each medicine must be appropriately labeled in an original container from the pharmacy or healthcare provider's office. Most pharmacies will provide an extra container for school use upon request. Administration of non-prescription medicines at school is discouraged.

Parent or Guardian's Permission: I give permission for my child to receive this medicine during school hours. I understand that it is my responsibility to purchase and supply this medicine. On behalf of my child I absolve Providence United Methodist Church, Providence United Methodist Church Weekday School and their agents and employees from any and all liability whatsoever that may result from my child taking this Medicine at school.

____ ___________________________________

Signature of Parent or Guardian Date Contact numbers (home, work., mobile, etc.)

FOR HEALTH PROFESSIONAL USE ONLY: ***PLEASE WRITE LEGIBLY USING LAYMAN'S TERMS***

Medication prescribed: ______________________________________ Strength/Dose: ______________________

Specific Directions (include exact amount to give, at what time and/or how often, relationship to meals. Specific indications if prn, etc.):

Purpose of Medication:____

Relationship to meals, if applicable____

How often and at what time (hour):____

Expected side effects or adverse reactions:____

Other instructions:____

____

It is necessary for this student to receive this medication during school hours in order to maintain or improve health and to benefit from school attendance.

____ ______________________ _____________________

Signature of health provider Date Telephone Fax

____ ____

Please print practitioner's last name **Practice name or address**