Barrington Christian Academy

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MEDICATION AUTHORIZATION FORM for ALL STUDENTS
For Prescription AND Over-the Counter Meds That Need to be Given During School Hours

_____

Student Name Date of Birth

_____

School Grade Teacher

This Section to be Completed by Your Child's Physician

Please give the medication prescribed by me as follows:

Medication: _____ Daily: _____ PRN: _____

Dosage in School: _____ Route: _____ Time: _____ Frequency: _____

Describe Indications/Diagnosis: _____ Side Effects: _____

Period to be administered/Other Instructions:

_____

Note: Inhalers /EpiPens/Other Emergency Medications require a different Emergency Plan form.

Meds other than Inhalers/EpiPens/Emergency Meds Kept in Health Office: I authorize this student to **self-administer** (if age-appropriate) the above medication under adult supervision in the health office if the part-time BCA School Nurse is unavailable. Yes: (MD initials)_____ No: _____

_____ _____/_____

Physician Signature *Physician name **(print)/Phone*** *Date*

This Section to be Completed by Parent/Guardian

I am aware that special permission is required for students to take medication during school hours. I give permission to Barrington Christian Academy to have my child _____ take the above medication during school hours.
(name)

Medication will be supplied by me in the **original prescription labeled container** with my child's name, name of medication, dosage and time to be given. I understand that if it is necessary for my child to take medication on a field trip away from school, I will provide one school day's supply of the medication in the original prescription bottle for my child to self-carry and self -administer.

_____

Parent/Guardian Signature Date Phone Number