FAIRFIELD CHRISTIAN ACADEMY
MEDICATION ADMINISTRATION AUTHORIZATION FORM
SCHOOL YEAR _____ - _____

Student Name _____ Home Phone_____
Grade _____ Address _____
Physician's name _____ Physician's office phone _____
Name of drug _____
Dosage _____ Time to be given at school _____
Drug is to be given 1.) by mouth _____ 2.) by inhaler _____ 3.) other _____
Start date _____ Discontinue after _____
Physician's signature _____
(Not needed if a prescription is less than one month old or for over-the-counter drugs)

I request and give my permission to school personnel to assist in the administration for this school year only on the listed medication to the student named above. I understand that the administration of this medication will not start until this form has been signed by the parent and the school nurse. I understand that the medication brought to school must be in the container in which it was dispensed by a physician or pharmacist. Over-the-counter drugs must be in the original container. I understand that adrenaline injections may only be administered by a registered nurse or by someone trained to administer the drug. I release Fairfield Christian Academy, its school board, its officials and employees including the school nurse and the appointed drug administrator from all liability for damages and injury directly or indirectly resulting from the performance or failure of performance of the assistance requested.

Signature of Parent/Guardian _____ Date _____

Signature of School Nurse _____

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