FAIRFIELD CHRISTIAN ACADEMY
MEDICATION ADMINISTRATION AUTHORIZATION FORM
SCHOOL YEAR 20_____ TO 20 _____

To be completed by parent or guardian:

- I request and give my permission to school personnel to assist in the administration of the listed medication to the student named below.
- I understand that the prescription medication brought to school must be in the container in which it was dispensed by a physician or pharmacist. Over-the-counter medication must be in the original container.
- I understand that epinephrine injections (EpiPen, Auvi Q) may only be administered by a registered nurse or 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 resulting from the performance or failure of performance of the assistance required.

Student name: _____ Grade: _____

Address: _____ Phone: _____

Signature of parent/guardian: _____ Date: _____

OVER-THE-COUNTER MEDICATION:

Name of medication _____Dose:_____

Time to be given: _____Start date: _____ End date: _____

PRESCRIPTION MEDICATIONS:

TO BE COMPLETED BY PHYSICIAN/PRESCRIBER:

Name of student _____ Diagnosis:_____

Name of Medication _____

Prescribed dosage and means of administration: _____

Time to be given: _____ Start date: _____ End date: _____

Possible side effects/adverse reactions: _____

Special Instructions: _____

Physician/Prescriber signature: _____ Date: _____