East Lake Academy

Thy Kingdom Come!

Authorization to Give Medication at School

Medication time schedules should be set so that, when possible, medicine is take at home rather than at school. However, if medication must be given during school hours, this form must be completed.

Please complete

Student Name_____ Birthdate_____

Teacher and Grade_____ Grade_____

I request that the East Lake Academy employee assists in administering the following medication to my child. I understand that:

- **Prescription medications must be authorized with a physician signature at the bottom of this form. Prescription medications will NOT be administered without physician consent.**
- **Over the counter medications require parent authorization only.**
- Medications must be in the original labeled container (no baggie, foil, etc.) Pharmacists can provide a duplicate labeled container with only the school doses.
- Parent/Guardian must provide the medication, related equipment required and specific instructions. The student may NOT bring these materials to school.
- Medication changes or dosage changes must be noted on a NEW medication authorization form. It is the responsibility of the parent/guardian to inform the school of any changes.
- New medication or dosage changes will not be given unless a newly labeled container is provided.
- Unused medication will be disposed of unless picked up within one week after medication is discontinued.
- Medication will be administered as follows:

Name of Medication_____

Dose_____ Administration Time(s)_____

Route (by mouth, topical, etc.)_____ Stop medication on_____

Symptoms in which child may require medication as necessary_____

_____

Condition/Illness requiring medication_____

Additional equipment required for administration_____

Possible side effects_____

Physician(s) name_____ Phone_____

I authorize the administration of the above stated medication while following under these directions:

_____ _____

PARENT SIGNATURE (FOR ALL MEDICATIONS) Date

_____ _____

PHYSICIAN SIGNATURE (FOR PRESCRIPTION ONLY) Date

Mom's Name_____ Dad's Name_____

Mom's Cell/Home_____ Dad's Cell/Home_____

A Medication Authorization Form must accompany each medication

Please make additional copies as needed