HUMBLE CHRISTIAN SCHOOL
Authorization and Permission for Administration of Medication

Student's Name _____ DOB _____
Last First MI

General Guidelines:

(1) Medications given more than 10 consecutive days require a physician's signature.
(2) Parent signature is required for the administration of any medication.
(3) Prescription and non-prescription medication must be in the original container.
(4) Changes in the administration of prescription drugs including dose and time must be in writing from the physician. Discontinuance must be in writing from the parent/guardian and/or physician.
(5) Medication label must contain the patient name, name of the medication, directions for use and date.
(6) Changes in the administration of non-prescription medications must be in writing from the parent/guardian and/or physician.
(7) Physician orders for medications are valid only for the current school year.
(8) Permission to administer "missed doses at home" must be in writing. Fax and e-mail are permissible. Original must follow within 48 hours.
(9) PRN meds may not be administered more than four times in one month.
(10) Medication must be **delivered to** and **picked up from** the clinic by a parent or authorized adult.

Parent/Guardian: Please give permission for school administration of medication

_____	_____	_____	_____
Medication	**Dosage**	**Frequency**	**Duration**

Start Date _____ Allergies_____

Special Instructions _____

Condition for which drug is to be given_____

Medications currently taken at home _____

Note: Non-prescription medications taken more than 4 times in a month will require a physician's order (signature is required) indicating maximum dosage allowed per month.

Parent please sign at the bottom of the medication form.

PHYSICIANS: PLEASE WRITE ORDER FOR SCHOOL ADMINISTRATION

Prescription medication given more than 10 days, non-prescription medication given more than 4 times in a month, or nonprescription medication when dosage is more than the recommended dosage on the container require a physician's order.

_____	_____	_____	_____
Medication	**Dosage**	**Frequency**	**Duration**

Start Date _____ Allergies_____

Special Instructions _____

Condition for which drug is to be given_____

Medications currently taken at home _____

Physician's name (print)_____ Physician's signature_____

Phone number_____ Fax number_____ Date_____

I request the above named student be given the medication at school by qualified staff, according to the prescription or non-prescription instructions and a record maintained. The student has experienced no previous side effects from the medication. I further agree that school personnel may contact the physician as needed and that medication information may be shared with school personnel who need to know.

I understand the law provides that there shall be no liability for civil damages as a result of the administration of medication where the person administering the medication acts as an ordinarily reasonably prudent person would under the same or similar circumstances. I agree to provide safe delivery of medication and equipment to and from school and pick up remaining medication and equipment or it will be properly destroyed.

Parent's Signature _____ Date_____

Daytime Phone_____ Other phone_____