BAYSHORE
CHRISTIAN SCHOOL

Medication Authorization

STUDENT INFORMATION

Student's Name: _____ Grade: _____
Teacher: _____ School Year: _____
Drug allergies/reactions: _____ Height (inches): _____ Weight (lbs):_____

PRESCRIBER (PHYSICIAN) AUTHORIZATION

Name of Medication: _____ Reason for Taking: _____
Dosage: _____ Route: _____ Frequency/Time(s) to be given: _____
Begin Medication (Date): _____ Stop Medication (Date): _____

Special Instructions:

Does medication require refrigeration? Yes ☐ No ☐
Is the medication a controlled substance? Yes ☐ No ☐
If asthma inhaler or emergency medication, do you recommend this mediation be kept "on person" by the student? Yes ☐ No ☐

Potential Side Effects/Contraindications/Adverse Reactions: _____
_____

Treatment order in the event of an adverse reaction (attach additional sheet or use the back of this for if necessary): _____
_____
_____

_____ _____ _____
Signature of Prescriber Date Phone Fax

PARENT AUTHORIZATION

I authorize unlicensed school personnel the task of assisting my child in taking the above medication. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize the school administration to talk with the prescriber of pharmacist should a question come up about the medication.

Medication must be turned in and registered with the school office. It must be in the original container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration, and the date of the drug's expiration.

_____ _____
Signature of Parent or Guardian Date Phone

REVISED 2/4/2015