



Waverly Hall Christian Academy

Medication Authorization Form

P.O. Box 40, 8365 Hwy 208 Waverly Hall, GA 31831-0040

Phone (706) 582-2228 * Fax (706) 582-2229

www.whchristian.org email office@whchristian.org **Student**

Information

Student's Name: _____ D.O.B. _____ Date: _____

Name of Medication: _____

Reason for Medication: _____

Dose: _____ Time/Frequency: _____

Doctor/Clinic: _____ Phone: _____ Dentist/Clinic: _____

Route: ☐ Oral ☐ Topical ☐ Inhaled ☐ Injection. ☐ Other _____ Current Grade Level _____

Date to start: _____ Date to stop: _____ Expiration _____

Additional Instructions/Comments: _____

For Prescription Medication

Prescribing Health Care Provider: _____ Phone Number: _____

_____ I authorize WAVERLY HALL CHRISTIAN ACADEMY to administer medication(s) named above to my child in the manner stated. I release any liability in relation to the administration of this medication. I also acknowledge that I, the parent/guardian, have given the first dose of this medication without any allergic or unexpected reactions.

Parent/Guardian printed name _____ Date Signed: _____

_____ Parent/Guardian signature: _____

RETURN OR DISPOSAL OF MEDICATION

Return Date: _____ Parent Signature: _____

Disposal Date: _____ Staff Signature: _____

_____ Witness to Disposal: _____

