Waverly Hall Christian Academy

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Medication Authorization Form

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

Other (specify): _____ **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 the 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: _____