REDLANDS CHRISTIAN SCHOOLS

□ **Arrowhead Christian Academy Upper School**
□ **Redlands Christian Middle School**
□ **Redlands Christian Lower School**

2019-2020 Authorization to Administer Medication(s)

Student Name:_____DOB:_____Grade: _____

To: Parent/Guardian and Physician

If a medication must be taken during the school day or during a school sponsored overnight trip, it is necessary, to have a written statement on file. The statement must be signed by the parent/guardian and the physician indicating a desire that designated school personnel assist the student with medication administration. **The authorization must be made annually and/or whenever a change occurs.**

We require that **ALL** medications, **prescription** and **over-the-counter** must have a completed statement from **BOTH** the physician **AND** parent/guardian **BEFORE** they can be administered. Medication must be provided in the **original container** labeled with the students name, medication name, dose/strength and **specific** administration directions.

Parent/Guardian Authorization

As the parent/guardian of the above named child, I request that designated school personnel assist in the administration of medication prescribed by the physician. I give consent for the physician and designated school personnel to communicate directly, regarding the administration of the medication. I understand it is my responsibility to bring all medication safely to the school and I agree to refill or replace medication as necessary. I understand that the medication will be stored in a locked area unless the physician indicates that my child is capable of carrying and self-administering it.

Signature:_____Date: _____

Physician Authorization

As the physician of the above named child, it is, in my professional opinion appropriate and necessary that the following medications be available for administration during the school day or during extended hours when the child is on school sponsored trips/outings/events.

Please place an "X" through any unused columns.

Name of Medication(s)	1.	2.	3.
Purpose of Medication			
Strength/ Dose			
Medication form (liquid, tablet, inhaler, etc.)			
Route of administration (oral, inhaled, injected, etc.)			
Scheduled administration time(s) or frequency if PRN			
Duration of need (if other than entire school year).			
Precautions, instructions, adverse effects or comments			
*Self-carry – for asthma inhaler or epinephrine auto-injectors ONLY.	Please Circle **Yes** **No**	Please Circle **Yes** **No**	
Physician Signature:		**Date:**	
Print Name:		**Phone:**	

Student Statement: I understand that I am allowed to carry and self-administer **ONLY** the medication(s) listed above. I agree to use the medication as instructed by my physician and not to share with other people. I understand that if I share the medication with others, I will be held accountable for my actions.

Student Signature: _____Date:_____