CORNERSTONE CHRISTIAN SCHOOL

Authorization for Administration of Medication

All over the counter medication must be brought in the original container with legible manufacturer's instructions. Prescriptions must be in original container with pharmacy label attached. No expired medications of any kind will be administered at school.

Student Name (print): _____**Grade:** _____

Medication is ordered to be given to a student at school only when absolutely necessary. Whenever possible, the parent and physician are urged to design a schedule for giving medication outside of school hours. If this is not possible, it must be understood by the parent that they medication will be dispensed by the school office personnel. ***The school accepts no responsibility for adverse reactions when the medication is dispensed in accordance with the physician's directions.***

Physician Prescribed Meds

Name of Medication:_____Date:_____

Dosage:_____Route:_____Time: _____

Purpose of Medication: _____

Physician's Name (print) _____Office Phone # _____

Physician's Signature: _____
(Signature required for prescription meds)

Over the Counter Meds

Name of Medication:_____Date:_____

Dosage:_____Route:_____Time: _____

Purpose of Medication: _____

I understand that it is my responsibility to furnish the medication and any medical equipment needed to administer the medication – both prescribed and over the counter meds.

Parent's Name (print) _____Phone # _____

Parent's Signature: _____
(Signature required for all meds - prescription and over the counter)

OFFICE USE ONLY Date Entered in RenWeb _____ Initials_____