HHCA Medication Authorization Form

If medication can be given at home or after school hours, please do so. However, if medication must be given during school hours, this form must be completed. Please write one medication per page.

Student's Name: _____

Teacher:_____ Grade: _____

I request that _____Happy Hollow Christian Academy____, through the principal or designee supervise/assist in the administering of medication to my child, according to the instructions below. I understand that:

- Medications must be in the original labeled container (no baggies, containers, etc.). Pharmacists can provide a duplicate labeled container with only the school doses.
- Parent/guardian must provide specific instructions, as well as the medication and related equipment to the principal or school nurse/personnel.
- It will be the responsibility of the parent/guardian to inform the school of any changes. New medication or new doses will not be given unless a new form is completed and a newly labeled container is provided.
- All medication will be taken directly to the office/clinic by the parent/legal guardian.
- Unused medication will be disposed of unless picked up by the end of the semester or school year respectively.

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Name of Medication: _____

Dose: _____ Route (by mouth, topical, etc): _____

Time(s) to be given: _____ Stop Medication on: _____

Condition/Illness Requiring Medication: _____

Possible Side Effects, if any: _____

Physician's Name: _____ Physician's Phone: _____

I hereby authorize the personnel, employees and officials of __Happy Hollow Christian Academy__ to assist my child in taking prescribed medication according to policy and I release them from any liability for administering this medication. I understand that, in the event of a change in medicine, I am responsible for presenting a new request form.

_____ _____

Parent/ Legal Guardian signature *Date*

Home Phone_____ Work Phone_____Pager/Cell Phone _____

To be completed by School Health Clinic Personnel only:

Date received: _____ Name of Medication: _____ # Doses: _____