West-Mont Christian Academy

873 South Hanover Street • Pottstown, Pennsylvania 19465
610-326-7690

AUTHORIZATION FOR SCHOOL MEDICATION ADMINISTRATION

Child's Full Name: ______________________________________Grade:___________________

Date of Birth:_________________ Allergies:____

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PHYSICIAN'S REQUEST

Name of prescribed medication(s):____
Reason:____ Dose:___________________________
Route:_______________________________ Time to be given at school:___________________
Side effects:____
Medication is to be administered _____ entire school year _____ daily _____ prn

____

Physician Signature

____

Printed Name

____

Date

____

Phone Number

****

PARENT REQUEST

I, the parent/guardian of________________________________ request that the employees (nurse, principal, or designee) of the West-Mont Christian Academy administer the above named medication as prescribed by my child's physician. My signature on this document constitutes a complete waiver of liability claim in any and all respects against West-Mont Christian Academy and its Board of Directors and all of its employees unless the Academy is negligent with regard to any claim for injury in connection with dispensation of the prescribed medication.

Additionally, I agree to provide the medication to the school in the original pharmacy or physician labeled container. I also accept responsibility to provide a physician's note and my written instruction if the medication is to be changed or discontinued. I give permission for the school and physician to communicate regarding this medication/medical condition.

Signature of Parent/Guardian___________________________________ Date______________

List all medication currently being taken by child:_____________________________________