Evangel Christian School
1277 Jubilee Dr. / Saraland, AL 36571

SCHOOL MEDICATION PRESCRIPTION/PARENT AUTHORIZATION

STUDENT INFORMATION

Students Name: _____

Grade: _____ Teacher: _____ Date: _____

List any known drug allergies/reactions _____Height (inches) _____ Weight (lbs)_____

PRESCRIBER AUTHORIZATION

Name of Medication _____ Reason for Taking (optional) _____

Dosage _____ Route _____ Frequency/Time(s) to be given _____

Begin Medication _____ Stop Medication _____
Date Date

Special Instructions:
Does medication require refrigeration? Yes ___ No ___
Is the medication a controlled substance? Yes ___ No ___
Is self-medication permitted and recommended for this student? Yes ___ No ___
If asthma inhaler or emergency medication, do you recommend this medication be kept "on person" by the student? Yes ___ No ___
Potential Side Effects/Contraindications/Adverse Reactions _____
_____
_____
Treatment Order in the event of an adverse reaction: (Attach additional sheet or use the back of this form if necessary) _____
_____
_____

_____ _____ _____ _____
Signature of Prescriber Date Phone Fax

PARENT AUTHORIZATION

I authorize an Evangel Christian School Staff Member the task of assisting my child in taking the above medication. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize this staff member to talk with the prescriber or pharmacist should a question come up above the medication.

Medication must be registered with the principal or his/her designee. It must be in the original container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration, and the date of drug's expiration when appropriate.

_____ _____ _____
Signature of Parent or Guardian Date Phone

I authorize and recommend self-medication by my child for the above medication.

_____ _____
Signature of Parent or Guardian Date

If any questions or problems arise, call me at: (H) _____ (W)_____

(Cell) _____

Evangel Christian School
Saraland, AL

MEDICATION CHART

Student's Name: _____ Grade: _____

Name of Medication: _____ Homeroom: _____

Physician: _____

Pharmacy Name: _____ Pharmacy #: _____

Reason for Medication: _____

Time(s) and Dosage given at: _____

Authorized by Parent/Guardian: _____

Special Instructions: _____

Medication Allergies: _____

Date	Time	Dosage	Initials	Date	Time	Dosage	Initials

Medication Sent To School

Date	Amount	Check in by	Date	Amount	Check in by

Name & Initial	Name & Initial
Name & Initial	Name & Initial
Name & Initial	Name & Initial