Pullman Christian School
Authorization for Administration of Medication at School
2016-2017

This portion to be completed by the parent/guardian.

Student Name_____ Date of Birth _____Grade_____

I am the parent, legal guardian, or other person in legal control of the below identified student and request/authorize the school to administer the medication listed below to my child in accordance with the licensed health professional's instructions for the period beginning (date) __/__/_____ through (date) __/__/_____ (not to exceed the current school year).

I understand that a dose may occasionally be missed despite every effort made by school staff to administer medication in accordance with the doctor's instructions.

Medication will be supplied to the school by me in the original container.

_____ _____
Parent/Guardian Signature Date

This portion to be completed by the licensed health professional.

Name of Medication: _____Dosage: _____

Time of day to be taken: _____

For the treatment of:_____

which is necessary during school hours.

This authorization is in effect from: __/__/_____ to __/__/_____

Possible side effects of medication:

_____

Emergency procedure in case of serious side effects:

_____

_____

_____ _____
Physician Signature Date

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