Pullman Christian School
Authorization for Administration of Medication at School
2020-2021

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***

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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:

____

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____ _______________________
Physician Signature ***Date***