CHAMPIONS CHRISTIAN ACADEMY

AUTHORIZATION FOR MEDICATION ADMINISTRATION

Student Name (print) Date of Birth

Known Medication Allergies

Parent/Legal Guardian Daytime Phone Number(s)

Emergency Contact Daytime Phone Number(s)

I request school personnel to administer the stated medication to my child during the school day. I hereby release Champions Christian Academy and employees of the Academy from any liability due to medication administration, allergic reactions, or adverse side effects of the drug. I understand that it is my responsibility to notify Champions Christian Academy in writing of any medication changes.

Furthermore, I consent and authorize the Champions Christian Academy nurse to communicate with the prescribing physician regarding my child's health condition and/or medication order as needed. This consent will remain in effect for the duration of the medication order.

Parent/Legal Guardian Signature Date

TO BE COMPLETED BY AUTHORIZING PHYSICIAN, P.A., OR NURSE PRACTICIONER

Medication: _____ Dosage (amount to be given): _____

Form of medication: _____ Route of administration: _____
(tablet, capsule, liquid, injection, etc.)

Time / Frequency / Circumstance medication is to be administered: _____

IF APPLICABLE
***Rescue inhaler can be repeated for severe breathing difficulty _____times _____minutes apart.

Length of time medication is to be administered: ☐ Current School Year ☐ Other, specify _____

Common side effects of medication: _____

Remarks: _____

Physician Signature Date

Physician Name (print) Phone Number Fax Number

School Office Use
*Date Completed Form on File:*_____ *Date Medication Received:* _____
CCA Nurse Signature: _____