Prescription Medication Authorization

Student's Name: ____

Teacher: ____ Grade: ___________________

I hereby request that Bridgeway Christian Academy through its designated authority, supervise/assist in the administering of medicine to my child, name noted above, according to the instructions contained on the physician's statement below. I release the school, the school board, and school employees from any liability for administering this medication.

Parent/Legal Guardian Signature: ____

Date: _______________________

MEDICATION INFORMATION:

Name of Medication: ____

Dosage: ____

Time(s) to be given during day: ____

Expected duration of administration of medicine - Last day to be given: ________________

Possible side effects, if any____

Other Comments: ____

Prescribing Physician's Name (Print)

____

Physician Phone Number:______________________________