Rock Creek Christian Academy

Physician's Medication Authorization For Prescription and Nonprescription Medication

ONE MEDICATION PER FORM

FOR COMPLETION BY PARENT(S)/GUARDIAN(S)

Full Name of Student _____ School year _____

Name of School _____ Grade _____

- I understand that I must supply the school with the equipment/supplies needed to administer the medication.
- I understand that all medications must be labeled with the name of the medication, name of the student, name of the physician, date, and directions for administration. Prescription medication must be labeled by a registered pharmacist.
- I hereby authorize the medication described below to be administered as directed by my child's physician.
- I understand that the physician will be called if a question arises about my child's medication.
- 911 will be called immediately in an emergency.

_____ _____

Signature of Parent/Guardian Date

FOR COMPLETION BY PHYSICIAN

1. Name and strength of medication _____
2. Reason for medication _____
3. Route of administration _____
4. Dosage of medication _____
5. Time of day medication is to be given _____
6. Date medication began _____ Date Medication discontinued _____
7. Side effects _____
8. Additional information _____
   (crush, dissolve, etc)

_____ Date _____

Physician's signature (original – NO stamp)

_____ _____

Physician's Printed Name *Physician's Phone Number*

_____

Physician's Address

Reviewed by School Health Services Staff _____

Name/Date

6707 Woodyard Rd, Upper Marlboro, MD 20772 ** 301-599-9600