PARKVIEW BAPTIST SCHOOL

STUDENT MEDICATION AUTHORIZATION FORM

**Any prescribed medication to be administered during school hours must be in the ORIGINAL LABELED CONTAINER AS DISPENSED BY THE PHARMACIST.

**ALL non-prescription medication must be brought in a NEW AND UNOPENED container.

Today's Date _____ **Student's Grade Level _____**

My child, _____has been prescribed medication and/or has permission to take non-prescription medicine.

He/She will take: (Medicine)_____

(Strength in mg)_____ (Dose)_____

Daily at_____(Time)

As needed _____

Other_____

I hereby authorize the following personnel to administer this medication to my child. (Please check)

_____School Nurse _____School Staff Personnel

_____Teacher/Substitute Teacher _____Other (Please specify) _____

*I release the school and the school board members, officers and personnel and will hold Parkview Baptist School and such persons harmless from any damages, liability or loss resulting from compliance or attempted compliance in good faith with this request and authorization.

* I recognize that I am primarily responsible for administering medications to my child and realize that Parkview Baptist School is not assuming my responsibility for my child's care but is acting only on my behalf when I am unable to personally administer a medication.

(Signature of Parent/Guardian) _____

Contact number _____Other Emergency Contact number_____