Summit Christian Academy
Medication Authorization Form

Student:_____School:_____Teacher_____

OVER-THE-COUNTER MEDICATION **TO BE COMPLETED BY THE PARENT**

Fill out and return to school with a **New Unopened Container** of age and dose appropriate medication

Medication:_____Dosage:_____

Purpose:_____Time(s) to be administered_____

Dates to be given:_____Allergies:_____

Special Instructions:_____

PRESCRIPTION MEDICATION **TO BE COMPLETED BY THE PHYSICIAN**

Summit Christian Academy encourages parents/guardians to administer medication to students before/after school, if possible. This form will only be valid for the current school year. A new form is required yearly.

PLEASE USE A SEPARATE FORM FOR EACH MEDICATION

Medication:_____Diagnosis:_____
Trade Name and/or Generic

Dosage:_____ Time(s) to be given at school:_____

Method of administration: ORAL ☐Liquid ☐Tablet ☐Inhaler DROPS ☐ Eye R L ☐ Ear R L

TOPICAL ☐ apply where_____ OTHER ☐ _____

Effective Dates: From___/___/___ to ___/___/___

Possible Side Effects:_____

If medication is PRN (as needed), please specify:_____
Signs and Symptoms

_____ Can Medication be Repeated? ☐Yes ☐No How Many Times?_____
Frequency of Administration

_____ _____ _____ _____
Physician's Name (Please Print) Physician or Representative Signature Physician's Phone Date

**** SELF-CARRY/SELF-ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL****

Provisions under 70 O.S. 1984, Section 1-1163, allow students to self-administer prescribed asthmatic, diabetic, or allergic medication. Approval to self-administer medications must be authorized by the prescribing physician. The parent or guardian of the student is to *provide the school an emergency supply* of the student's medication.

☐ I have instructed _____ in the proper use of his/her medication and it is my professional opinion that this student is capable of self-administration of the medication and should be allowed to carry and use that medication by himself/herself.

_____ ___/___/___
Physician's Signature Date

TO BE COMPLETED BY THE PARENT/GUARDIAN

I have read the procedure for medication administration, and I hereby request and authorize Summit Christian Academy personnel to administer this medication as directed. I agree to release, indemnify, and hold harmless Summit Christian Academy and any of their officers, staff members, or agents from lawsuit, claim, demand, or action against them for administering medication to this student. **I understand that *permission is granted* for exchange of written communication between the school and the prescribing physician/dentist regarding this medication.**

_____ ___/___/___ _____

Signature of Legal Parent/Guardian **Date** **Contact Phone**

SUMMIT CHRISTIAN ACADEMY