Midland Classical Academy
Authorization and Permission for Administration of Medication

Student Name_____**DOB**_____
Last First MI

GENERAL GUIDELINES:

(1) Parent signature is required for the administration of any medication.
(2) Prescription and non-prescription medication must be in the original container.
(3) Changes in the administration of non-prescription/ prescription drugs, including dose and time, must be in writing from the parent/guardian and/or physicians.
(4) Medication label must contain the patient name, name of the medication, directions for use, and date.
(5) Physician orders for medications are valid only for the current school year.
(6) Daily & emergency medications will be sent with a teacher on a field trip unless otherwise notified.

Parent/Guardian: Please Give Permission for School Administration of Medication

Non-prescription medications taken more than 4 times in a month will require a physician's order indicating maximum dosage allowed per month.

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Medication **Dosage** **Frequency** **Duration**
Start Date_____Allergies_____

Special Instructions_____

Condition for which drug is to be given_____

Medications currently taken at home_____

Physicians: Please Write Order for School Administration

Prescription medication given more than 10 days, non-prescription medication given more than 4 times in a month, or non-prescription medication when dosage is more than the recommended dosage on the container require a physician's order.

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Medication **Dosage** **Frequency** **Duration**
Start Date_____Allergies_____

Special Instructions_____

Condition for which drug is to be given_____

Medications currently taken at home_____

Physician's name (print)_____Physician's signature_____

Phone number_____Fax number_____Date_____

I request the above-named student be given the medication at school by qualified staff, according to the prescription or non-prescription instructions and a record maintained. The student has experienced no previous side effects from the medication. I further agree that school personnel may contact the physician as needed and that medication information may be shared with school personnel who need to know. I understand the law provides that there shall be no liability for civil damages as a result of the administration of medication where the person administering the medication acts as an ordinarily reasonably prudent person would under the same or similar circumstances. I agree to provide safe delivery of medication and equipment to and from school and pick up remaining medication and equipment or it will be properly destroyed.

Parent Signature_____**Date**_____**Phone**_____