TRADERS POINT CHRISTIAN SCHOOLS

TRAINING SCHOLARS. MAKING DISCIPLES. GRADUATING LEADERS.

Permission to Administer Medication

(one medication per page)

Permission is hereby granted to the school nurse or his/her designee to supervise my child in taking the following prescribed/OTC medication.

I hereby release and discharge Traders Point Christian Schools and its employees from any and all liability in case of an accident or any other mishap in supervising said medication due to any side effects, illness or other injury which might occur to my child through supervising said medication.

I understand that:

- All medications must be approved by the U.S. Food and Drug Administration and appear in the U.S. Pharmacopeia.
- Medications MUST be in the original container/packaging and include the original prescription label from the pharmacy with student's name, DOB, medication name, dosage, route and frequency.
- OTC medications MUST be in the original container/packaging.
- It will be the responsibility of the parent/guardian to inform the school of any changes in pertinent data related to the medication(s).
- New medications will not be given unless a new form is completed.
- All medications (including OTC) will be taken directly to the front office or school nurse office by the parent or guardian. Students may NOT have medications in their possession, except with a physician's request on file.
- A daily record shall be kept on each medication administered at school.
- At the end of the school year, any and all medications must be picked up by a parent/guardian. Any medication not picked up from the school by the end of the last school day or the year will be considered abandoned. Abandoned medication will be properly discarded in accordance with local, state, and federal laws/rules by the school nurse and another school employee.

Name of Student:_____ DOB:_____

Medication:_____ Dosage:_____

Frequency/Time:_____ Route:_____

Special Insstructions:_____

I hereby give my permission for my student to receive this medication at school.

Parent/Guardian Signature:_____ Date:_____

To be signed by a Healthcare Provider for long-term medications (more than 2 weeks).

Healthcare Provider Name:_____

Healthcare Provider Signature:_____ Date:_____

Reviewed by School Nurse:_____ Date:_____