GRACE COVENANT ACADEMY

2023-2024 Medication Authorization Form

Parents should complete this form and return to the Health Room by the first day of school.

PLEASE NOTE: ALL MEDICATIONS REQUIRE A PHYSICIAN'S SIGNATURE. ABSOLUTELY NO MEDICATIONS WILL BE GIVEN EITHER PRESCRIPTION OR OVER THE COUNTER (OTC) UNTIL THIS AUTHORIZATION HAS BEEN RECEIVED.

Student Name:

Last _____ First _____ Middle _____ Grade____

Date of Birth _____ Address _____

Parent/Guardian Name _____ Telephone _____ Cell _____

TO BE COMPLETED BY PHYSICIAN: Authorization for medications to be administered during the academic day and all school sponsored events.

SECTION 1: Please check the following OTC Medication(s) that the student may be given and list any prescription medications to be given during the school year.

Student Weight _____ lbs

Tylenol/generic ___ Yes (Dosage _____) ___No

Motrin/generic ___ Yes (Dosage _____) ___No

Benadryl (allergic reactions) ___ Yes (Dosage _____) ___No

Hydrocortisone (topical analgesic) ___ Yes ___No

Antacids (Tums) ___ Yes ___No

Throat Lozenges ___ Yes ___No

Calagel (topical anti-itch analgesic) ___ Yes ___No

Triple Antibiotic Ointment ___ Yes ___No

SECTION 2: Please complete the following for any prescription medication or additional OTC (I.E. Allergy Medication, etc.) to be given during the school year.

The above name student is under my care for (diagnosis) _____

Medication to be administered during school hours: _____

Dosage/Route/Frequency _____ Administration: Begins _____ Ends _____

Possible side effects: _____

EMERGENCY MEDICATIONS (i.e. EpiPen, Inhaler, etc.) may be carried by the student (Grades 6 - 8 only) and self administered if the physician indicates below and considers the student sufficiently responsible. Action Plan Required. Parents should supply the health room with additional emergency medications as a precaution.

Does student (Grades 6 - 8 only) carry and self administer this medication for emergencies? ___ Yes ___No

NOTE: Middle School (Grades 6 - 8) students are given permission to carry and self administer over the counter and prescription medications and emergency medications for co-curricular activities if a parent and student initial below acknowledging understanding and compliance of medication policy (review online). This privilege does not apply to controlled medications (i.e. ADD medications or narcotics.)

_____ Parent initials _____ Student Initials

Signature of Physician, CRNP or PA: _____ Phone # _____

Printed name of Physician, CRNP or PA: _____ Date: _____

The above medication order is valid 8/1/23 - 7/31/24

An **Action Plan** for is required for students with a history of asthma, diabetes, allergic reactions or seizures requiring treatment. This form must be completed by the physician. ***Action Plan** form may be obtained from the school nurse.

TO BE COMPLETED BY PARENT/GUARDIAN

I request the medication listed above be given to this student during school hours and all school sponsored events. I understand that only I, or the school nurse or appointed school personnel, may administer this medication during school hours or school sponsored events to this student. I acknowledge that the school shall incur no liability as a result of any conditions from the medication. I shall hold harmless the school, its employees or agents against any claims arising from the administration of medication given to this student.

Signature of Parent: _____ Date: _____

Parents please initial any special directives added in the space below regarding the student medication:

_____ I will pick up any unused medication on the last day of school.

_____ Please discard any unused medication on the last day of school.

All medication will be discarded if not picked up by the last day of school.