School Year: _____

Trinity Christian Academy
Authorization for Medication Administration by School Personnel

Medication Information: <u>Must be in the Original Labeled Container.</u>

Student's Name: _____ DOB: _____

Grade: _____ Teacher's Name (Homeroom): _____

Diagnosis for Medication: _____

Name of Medication: _____

Dose as directed on label: _____ Time to give: _____

Start Date: _____ End Date: _____

Special Instructions: _____

All medication will be stored and dispensed from the school clinic during school hours only. Students are not permitted to carry and/or self-administer medication excluding life-sustaining medications.

Rescue Inhalers for Asthma: Choose all that apply

- ❑ An inhaler will be kept in the clinic.
- ❑ The student will carry the inhaler. Grades 3 – 12 only. Requires written physician authorization.*

EpiPen for Anaphylaxis: Choose all that apply

- ❑ An EpiPen will be kept in the clinic.
- ❑ The student will carry the EpiPen. Grades 5 – 12 only. Requires written physician authorization.*

*Written Physician Authorization must be on file. The medication must display the pharmacy label. Emergency Action Plan must be completed. The school reserves the right to rescind this order at any time.

Parent Authorization:

I authorize permission for the staff of the school clinic to administer my child his/her medication as indicated above. I understand that I am responsible to bring this medication to school and maintain the supply as needed.

Parent Signature: _____ Date: _____

Primary Contact: _____ Relationship: _____

Primary Contact Number: _____ _____

Email Address (for medication updates) _____

Secondary Contact: _____ Relationship: _____

Secondary Contact Number: _____ _____