



2020-2021 School Authorization to Give Medication at School

If medication can be given at home please do so; however, if medication must be given during school hours, this form must be completed.

Scholar's Name: _____

Teacher: _____ Grade: _____

I understand that for Arlington Christian School's office staff to administer medication to my child during school hours is done so as an accommodation for my convenience and that Arlington Christian School does not employ a full-time nurse. I understand that it is the responsibility of my child to report to the office for his/her medication and agree that I will not hold Arlington Christian School responsible for my child not taking his/her medication. With this understanding, I hereby request that Arlington Christian School, through the director or designee, supervise/assist in the administering of medication to my child according to instructions on the medication label. I understand that:

- Prescription or non-prescription medications **MUST** be held for my child in the school office (other than an inhaler) and not held by my child or held in the classroom.
- Medications **must** be in the original labeled container (no baggies, foil, etc.)
- Parent/Guardian must provide specific written instructions, as well as the medication and related equipment, to the director or designee.
- It will be the responsibility of the parent/guardian to inform the school of any changes. New medication or new doses will not be given unless a new form is completed.
- All medication will be taken directly to the office/clinic by the parent.
- I will provide only the quantity of medication that is necessary for the number of days specified by the physician and that any unused medication will be disposed of unless picked up within one week after school dismisses.
- It is the responsibility of the parent/guardian to ensure that medication has not expired.

Name of Medication: _____

Physician Name: _____ Physician Phone: _____

I release Arlington Christian School, the Arlington Christian School Board of Trustees, and any school employee from any liability for administering this medication.

Parent/Legal Guardian Signature Date

Home Phone: _____ Work Phone: _____ Cell: _____

To be completed by physician for prescription medications given for more than two weeks.

Condition/Illness requiring medication: _____

Possible side effects if any: _____

Signature of Physician Date

