Physician Authorization Form for Prescribed Medication

Student's Name ________________________________ Date of Birth ____________________

Student's Address ______________________________ Phone __________________________

School Branch _________________________________ Grade __________________________

Medication to be administered _______________________________

Does this medication have a generic name? _______________________

Dosage to be administered __________________________________

Time/ interval when to be administered: _________________________

Date to begin administration__________________ Date to Cease administration_______________

Possible adverse reactions or side effects ____

List of severe reactions that should be reported to the physician ______________________________

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Special instructions for storage of medication____

Special instructions for administration of medication _____________________________________

Physician's Name ________________________________Phone __________________________

Address ______________________________________Emergency Phone _________________

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Physician's Signature Date

I give my permission for Tree of Life Christian Schools to administer the ***prescription medication*** listed above to my child ___________________________________ (child's name) at the time and dosage stated by the physician.

- I understand it is my responsibility to send an appropriate supply of medication I want Tree of Life to administer to my child during the current school year in its ***original container with my child's name on it***. This should be turned in to the front office. NO medication is permitted in book bags and/or lockers (**).
- The school reserves the right to prohibit the administration of any medications or procedures that appear to be beyond the ability of school personnel.
- The prescription medication for the student listed above cannot be scheduled for other than school hours. I agree to notify the school in writing of any changes in my child's condition with respect to the administration of medicine or with any changes to the information provided on this form.
- The school will keep a written account of medication administered to my child in school throughout the current school year.
- I do hereby release Tree of Life Christian Schools and any persons, employees, etc. designated by Tree of Life Christian Schools from and against any and all claims, demands or causes of action by any person for loss, cost, injury or damage alleged to rise from or out of the administration of medical services as requested above and authorized below.

____ ______________________________

Parent's/Guardian's signature Date

** Ohio state law permits students to carry metered dose or dry powder asthma inhalers and/or epipens approved by the student's physician and parents. If you are giving permission for your child to carry his/her inhaler and/or epipen on school premises or to school functions rather than keeping it in the school office, please initial here. _____

(Revised 2012)