Cornerstone
CHRISTIAN ACADEMY
FOR LEARNING & LEADERSHIP

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT CORNERSTONE CHRISTIAN ACADEMY

Student:_____ Date of Birth: _____Grade:_____

THIS PORTION TO BE COMPLETED BY THE PHYSICIAN

Medication:_____ Dosage:_____

Method of Administration and time of day to be taken:_____

Reason for medication to be given during school hours:_____

_____

Possible side affects of medication:_____

_____

Emergency procedure in case of serious side affects:_____

_____

I request and authorize that the above named student be administered the above identified medication in accordance with the instructions above for the period commencing with the _____ day of _____, 20____ through the _____ day of _____, 20___ as there exists a valid health reason which makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials. Such medication may be administered by medically untrained school personnel.

_____ _____

PHYSICIAN/DENTIST (Print Name) DATE

_____

SIGNATURE **(We recommend that PA orders be countersigned by the supervising physician)**

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I certify that I am the parent, legal guardian or other person in legal control of the above identified student and request and authorize Cornerstone Christian Academy to administer the above identified medication to the above identified student in accordance with the prescription or doctor's instructions for the period beginning on the _____ day of _____, 20____ through _____ day of _____, 20____(not to exceed one school year).

Medication shall be supplied to the school in the original container

_____ _____

PARENT/LEGAL GUARDIAN (Print Name) DATE

_____

SIGNATURE