



Authorization for Prescription Medication

Date: _____

Student Name: _____ Grade: _____

Medication Name: _____

Amount to be given: _____ Hour(s) to be given: _____

Directions:

This authorization form must be maintained and is only valid for the duration of the prescription. Once it expires, I must fill out a new form. I hereby give permission to dispense the medication listed above in accordance with the written directions on the prescription's label.

I agree that the student listed above has received this medication at a prior point in their life. Wesley Christian Academy cannot give a student a new medication for the first time to assist in avoiding allergic reactions. I understand that if the student exhibits signs of an anaphylactic allergic reaction to a medication given will result in 911 being called and the student being transported by ambulance. The student's family is financially responsible for emergency care necessary for reactions to medications.

Parent/Guardian PRINTED NAME

Parent/Guardian Signature

Date

Physician's Name

Physician's Signature

Date

Parent Contact Information: Wesley Christian Academy will contact the following people in this order in case of an emergency:

First Phone Number: _____

Name: _____

Relation: _____

Second Phone Number: _____

Name: _____

Relation: _____

