FIRST ASSEMBLY CHRISTIAN SCHOOL
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Authorization for Administration of Medications

Academic Year_____

Name of Student: _____Grade:_____Birth Date:_____Date:_____

Medication Allergies: _____

Diagnosis for which medication is given:_____
(i.e. Behavioral, Seizure, Asthma, Diabetes, etc.)

Medication Name: _____ Dosage:_____ Route:_____

Form (pill, inhaler, liquid)_____ How often to be given:_____

Relevant Side Effects:_____

Discontinuation Date: _____
(All medications will be discontinued at the end of the academic school year unless otherwise noted.)

Authorization by Parent/Guardian:

I hereby request that the school nurse/assistant administer the above medication. I understand that I **must** supply the school with the original prescription container (label intact) or the non-prescription container in compliance with the FACS Medication Policy.

Is the student physically and mentally able to self-administer the medication with assistance? YES____NO____

The undersigned agree not to file or make any claim against anyone for negligence in connection with the administration or non-administration of any medications and further agree to save such individuals and hold them harmless from any liability incurred as a result of the administration or non-administration of any medicines.
I have read and understand the Guidelines for Administration of Medication and will abide by them.

Physician's Signature (prescription drugs only)_____Dates: _____

Parent/Guardian Signature:_____Dates: _____

Medication Returned to Parent/Guardian:

Date_____ Signature_____

GUIDELINES FOR MEDICATIONS

Medications should be limited to those required during school hours and necessary to maintain the student in school. Daily or twice daily prescription medications will not be given at school. It is recommended that all medication be brought to the Health Office by parent/guardian. Parents understand that **they must supply the school with the original prescription container (label intact) or the non-prescription container such as Tylenol, Motrin, Benadryl, etc**…in compliance with the state department of health medication policy.

1. All **prescription** medications must be in the **original pharmacy-labeled container**. The container shall display:

   - Student's name
   - Prescription Number
   - Date
   - Medication Name and Dosage
   - Administration Route or Other Directions
   - Licensed Prescriber's Name
   - Pharmacy Name, Address, and Phone Number

Changes in prescription medications shall have written authorization from the licensed prescriber and parent.

2. All **non-prescription** medications must be in the **original container** with label intact and legible. The container shall display:

   - Student's name and grade
   - Visible Expiration date

3. All Medications require **written authorization before a student can be administered medication at school.** The parent/guardian is required to designate that the student is able to self-administer the medication with assistance.

Medications administered during school hours must be renewed by parent/guardian written consent annually.

4. **All medications must be kept in the Health Office NOT with the student**.

5. With parent/guardian authorization, students with asthma requiring prescription may have relief inhaler with them for immediate use.

6. Students with prescribed EPI-Pens, Glucagon, etc…will have medication administered by the school nurse as prescribed or needed.

7. **Expired medication will NOT be given** at school.

Failure to follow the above guidelines means medication cannot be given at school.