Family Christian Academy

A Ministry of Family Church PC

Charlotte County Health Department
Private Schools
Parent and Physician Authorization Form
Administration of Medication During School Hours

Physician:

Child's name: _____

Name of medication: _____

Time to be given: _____

Dosage to be given: _____

Duration of time child is to receive medication: _____

Reactions to monitor for: _____

Physician's signature: _____ Date: _____

Please print physician's name, address, phone number and fax number:

Name: _____

Address:_____

Phone: _____ Fax: _____

Parent/Guardian please sign the following:

I hereby give my permission for the school to administer the medication prescribed by my physician for my child.

Parent's signature: _____ Date: _____