BELLEVUE CHRISTIAN SCHOOL - MACK ELEMENTARY CAMPUS
AUTHORIZATION FOR ADMINISTRATION OF ORAL MEDICATION AT SCHOOL

Student Name: ___________________________ Date Med Rec'd ________Date Exp. Logged _________

Birthdate: __________________ Teacher: ______________________ Grade: ________

Parent Name: _________________________Phone: (hm) _______________ (wk)____________

THIS PORTION TO BE COMPLETED BY THE PHYSICIAN

(A SEPARATE FORM MUST BE COMPLETED FOR EACH DIFFERENT MEDICATION)

MEDICATION	DOSAGE	METHOD OF ADMINISTRATION	TIME OF DAY TO BE TAKEN
____________________	_______________	___________________________	____________

DATES TO BE ADMINISTERED: From ________day of _______ , through the _______ day of _______

Reason for medication to be given during school hours: ____

Potential symptoms that indicate medication is advised: ____

____

Possible side effects of medication: ____

____

Emergency procedure in case of serious side effects: ____

I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated on this form. There exists a valid health reason which makes administration of this medication(s) 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 Signature: ___________________________________ **Date:** ____________________
(We recommend that PA orders be countersigned by the supervising physician)

Physician Name (type or print): ____

Address: ____ **Phone:** _______________

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I certify that I am the parent/legal guardian of the above identified student and request and authorize the school to administer the above identified medication to the above identified student in accordance with the prescription or doctors instructions for the period beginning the ________day of ________, through the _______ day of ______ (not to exceed one school year).

MEDICATION MUST BE SUPPLIED TO THE SCHOOL IN THE ORIGINAL CONTAINER

Parent/Guardian Signature: _____________________________________ **Date:** ____________

BCS Mack Elementary Office Fax#: 425-481-1167