Legacy Christian Academy
School Medication Administration Authorization Form
Prescription or Non-Prescription Medication

Legacy Christian Academy Clinic
1101 Wesley Ave., Xenia OH 45385
Phone: 937-352-1655
Fax: 937-352-1641

Student's Name: *** Only one student name per form***		Grade:
Address:		Phone
City:	State:	Zip:

Medication Name: *Only list one medication per form*	**Dosage:**
Time/Frequency of administration:	**Special instructions for administration or storage:**
Date administration is to begin:	**Date to cease:**
Severe adverse reactions that should be reported to the physician:	

Required for prescription medications only

Physician's name and address:

One or more of physician's phone number:

Phone:	**Phone:**	**Fax:**
Physician's signature:		**Date:**

This form must be completed entirely in order for medication to be administered.
All medications must be in the original container with label intact.
All prescription medications need to have the dosing information completed and signed by a physician.
Any changes to prescription medication dosage or administration need to be signed by a physician.

Emergency Medication Self Carry/Administration Authorization/Approval

Self carry/administration of emergency medication may be authorized by the prescriber and must be approved by the school nurse according to the State Medication Policy.

Prescriber authorization for self carry/administration of emergency medication:_____
School Nurse approval for self carry/self administration of emergency medication: _____

Parent/Guardian Authorization

I/We request designated school personnel to administer the prescription medication as prescribed by the above prescriber. I/We request the designated school personnel or volunteer nurse to administer the non-prescription medication as directed above. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We authorize the school nurse to communicate with the health care provider if needed.

Parent/Guardian Signature_____Date:_____
Home Phone #:_____Cell Phone #_____Work Phone #_____