Boca Raton Christian School

PHYSICIAN'S AUTHORIZATION OF MEDICATION/TREATMENT FORM FOR OVER THE COUNTER AND PRESCRIPTION MEDICATIONS

Student Name ______________________________ Grade __________

Medication ______________________ Dosage ______________________

Purpose and type of treatment ______________________________

Time and directions for dispensing medication ______________________

____

Please list any possible side effects/special instructions ______________________

____

Physician's Name ____________________ Telephone ________________

Physician's Signature ______________________ Date ______________

Parent's/Guardian's Signature ____________________ Date ______________

The school has my authorization to administer the above medication to the student named above.

(Over)

Boca Raton Christian School

PARENT'S PERMISSION

Student Name ____________________________ Grade ____________

I hereby give permission for my child to receive medication during school hours. I understand that Boca Raton Christian School undertakes no responsibility for the administration of medication. The medication has been prescribed by a licensed physician. I hereby release Boca Raton Christian School and its agents and employees from any and all liability that may result from my child taking medication.

Parent Signature ____________________________ Date ______________

This form must be completed annually and for each change in dosage. Medication which has been prescribed to the school must be sent to school in the original container. (If the physician prescribes Tylenol, the school has a supply on hand.)

BRCS Fax: 561-367-6808

Please print form and take to doctor to complete. Doctor may fax back or parent can return it to the school.

If faxed, please mark ATTN: School Nurse