Michiana Christian Academy

HEALTHCARE PROVIDER INSTRUCTIONS FOR MEDICATION ADMINISTRATION

Student Name: _____ Date of Birth: _____

Student Age: _____ Grade: _____

Medication Allergies: _____ Medical Conditions: _____

OVER-THE-COUNTER MEDICATION

I give permission for my student to be administered the following over-the-counter medications if needed. Please note, the parent is responsible for providing these medications to the school and they will be given ONLY according to the instructions given by the healthcare provider on this form.

Name of Medication	Dose	Instructions for Use	Frequency	Reason for Use	Termination Date of Medication
					Date: OR End of School Year
					Date: OR End of School Year
					Date: OR End of School Year

PRESCRIPTION MEDICATION

I give my permission for my student to be administered the following prescription medications as directed by his/her healthcare provider. All prescription medication must be kept in the original bottle with the instructions and student's name clearly labeled. Medication should only be transported to the school by parents.

Name of Medication	Dose	Instructions for Use	Frequency	Reason for Use	Termination Date of Medication
					Date: OR End of School Year
					Date: OR End of School Year
					Date: OR End of School Year

Parent Signature: _____ Date: _____
(required for prescription and over-the-counter medications)

Healthcare Provider Signature: _____ Date: _____
(required for prescription medications only)

Reviewed By: _____ Date: _____

Michiana Christian Academy

PERMISSION FOR SELF-ADMINISTRATION OF MEDICATION

To Be Filled out by Parent:

Student Name: _____ Date of Birth: _____

Student Age: _____ Grade: _____

Medication Allergies: _____ Medical Conditions: _____

I certify that the information provided on this form is accurate to the best of my knowledge. I acknowledge that it is my responsibility to make sure my student knows how and when to appropriately use the medications listed below. I understand that Michiana Christian Academy is not liable for any misuse or loss of medication.

Parent Signature: _____ Date: _____

To Be Filled out by Healthcare Provider:

This child has a chronic medical condition that requires him/her to carry medication with him/her at all times.

Name of chronic medical condition: _____

Please note the medication below that must be carried by the student at all times.

Name of Medication	Dose	Instructions for Use	Frequency	Reason for Use	Termination Date of Medication
					Date: OR End of School Year
					Date: OR End of School Year

I certify that _____ (student's name) has been appropriately instructed on the self-administration of the above medication(s). I also certify that it is medically necessary for this student to carry the prescription medication(s) at all times as it may need to be emergently administered.

Healthcare Provider Signature: _____ Date: _____
(required for prescription medications only)

Reviewed By: _____ Date: _____