NAMPA CHRISTIAN SCHOOLS

Authorization to Administer Medication

Date:

I request that authorized school personnel administer medication according to the following:

Student name:	
Prescription name:	
Prescribing provider name:	
How often is it given?	
Reason for taking medication:	
How long has your child been taking this medication?	
Amount to be given:	
Time to be given:	

All prescription medication will be given and recorded in the school nurse's office by approved personnel. Please note if you would like your student to keep their medication (ie. Asthma inhaler, epi pen) in the classroom.

I will supply dosage each week/month and will not hold Nampa Christian Schools nor individual employees of the school responsible for error in the administering of this medication.

I understand that self-administration of medication is a privilege. I will help my child abide by the guidelines while receiving medication at school. I will warn my student concerning the dangers and inappropriateness of sharing medication with anyone at school.

PARENT'S SIGNATURE:
DATE: