United Faith Christian Academy
Christ-centered, College Prep School

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Medication Authorization Form

Student Legal Name

_____/_____/_____/_____
Last First Middle Preferred

Address _____ City _____ State _____ Zip

Date of Birth _____/____/____Gender (please circle) M F Student Cell # _____ Grade *Entering* _____

HEALTH HISTORY – 2016-17 MEDICATION AUTHORIZATION FORM
(Instructions: Parent should complete this form and return to the UFCA Academy Office. **Please note: the Medical Information/Emergency Release Form is required to be on file before the student will be allowed to attend school.**

List any health information (past and present such as diabetes, asthma, allergies, seizures, migraines, ADD/ADHD, etc.) Also, please list any current medications that your child is taking.

_____
_____

Date of last Tetanus _____

TO BE COMPLETED BY A PHYSICIAN

Authorization for any medications to be administered during the academic day and school sponsored events.

SECTION 1: Please check the following OTC (Over the Counter) medication(s) that the student may be given and also list any prescription medications to be given during the school year.

Tylenol/generic	____ Yes	____ No
Motrin/generic	____ Yes	____ No
Benadryl (for allergic reactions)	____ Yes	____ No

SECTION 2: Please complete the following for any prescription medication or additional OTC (i.e. allergy medication, etc.) to be given during the school year.

The above listed student is under my care for (diagnosis):
_____

Medication to be administered during school hours:
_____

Dosage/Route/Frequency: _____

Administration to begin: _____ Administration to end: _____

Possible side effects:
_____

EMERGENCY MEDICATIONS (i.e. EpiPen, inhaler, etc.) may be carried by the student and self-administered if the physician indicates below and considers the student sufficiently responsible. **ACTION PLAN REQUIRED**. Parents will supply the Academy Office with additional emergency medications as a precaution.

ALLERGIES: Please list allergic reactions that may require emergency medical treatment: (i.e food, drug, seasonal or allergic reactions to bees/insects)

_____

Does the student carry and self-administer this medication for emergencies? (Circle one) Yes No
Please list any daily medications that the student will need to take during co-curricular activities (after school) and during school hours that they are authorized to self administer.

Medication	**Dosage**	**Frequency/Time Duration**	**Medication**	**Dosage**	**Frequency/Time Duration**
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Signature of Physician, CRNP or PA: _____
Phone#:_____