United Faith Christian Academy
Christ-centered, College Prep School

8617 Providence Road, Charlotte, NC 28277
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2017-18 Authorization to Administer Medications

Student Name: _________________________/_________________________ Grade *Entering* _____________
Last First

TO BE COMPLETED BY A PHYSICIAN ONLY IF ANY MEDICATIONS TO BE ADMINISTERED TO THE STUDENT DURING THE ACADMIC DAY OR SCHOOL SPONSORED EVENTS (Rx or Over the Counter).

SECTION 1: Please check the following OTC (Over the Counter) medication(s) the student may be given AS NEEDED.

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

SECTION 2: Please complete any prescription medication or additional OTC (i.e. allergy medication, etc.) to be given during the 2017-18 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 (SEPARATE FORM) REQUIRED**. Parents must 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)

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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).

Medication	**Dosage**	**Frequency/Time Duration**	**Medication**	**Dosage**	**Frequency/Time Duration**
____________	________	____________	____________	________	____________
____________	________	____________	____________	________	____________

Signature of Physician, CRNP or PA: ______________________________ Phone #: ______________________

Printed Name of Physician, CRNP or PA: ____________________________ Date: ______________________
(The above medication order is valid 8/01/2017 – 8/01/2018)

THE ACTION PLAN FORM is required for students with a history of asthma, diabetes, allergic reactions or seizures requiring treatment. This form must be completed by a physician. *Action Plan form may be obtained from the Academy Office or under Admissions on the UFCA website: www.ufca.org

TO BE COMPLETED BY PARENT/GUARDIAN
I request the medication listed above be given to this student during school hours and all school-sponsored events. Medications will only be accepted in the original container along with a doctor's signature for that medication. I understand that only I, or the school nurse or appointed school personnel, may administer this medication during school hours or school sponsored events to this student. I acknowledge that the school shall incur no liability as a result of any condition from the medication. I shall not hold the school, its employees or agents against any claims arising from the administration of medication given to this student.

Signature of Parent: ______________________________ Date: ______________________

ALL MEDICATIONS WILL BE DISCARDED IF NOT PICKED UP BY MAY 31, 2018.