# United Faith Christian Academy

**Christ-centered • College Prep School • PreK – 12th Grade**
8617 Providence Road, Charlotte, NC 28277
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## 2018-19 Authorization to Administer Medications

**To be completed by a doctor if medications are to be administered during school hours, school sponsored events and/or co-curricular activities (after school), both prescription and over the counter. Parent/guardian signature required.**

Student Name: ___________________________/________________________/_______ DOB___/___/______Grade *Entering* _______
Last First Middle Initial

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

| | | | Dosage |
|---|---|---|---|
| Tylenol/generic | ____ Yes | ____ No | _____________ |
| Motrin/generic | ____ Yes | ____ No | _____________ |
| Benadryl/generic (*forallergic reactions*) | ____ Yes | ____ No | _____________ |
| Other ______________ | ____ Yes | | _____________ |

**Please Note**: OTC medications must be provided by the parent to the Academy Office, labeled with student name, grade and dosage**.**

## SECTION 2: Please list any prescription medication(s) to be given for the 2018-2019 school year.

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

| Medication(s) | Dosage | Frequency/Time Duration | Possible side effects |
|---|---|---|---|
| ___________________________ | _____________ | _______________________ | _____________________________________ |
| ___________________________ | _____________ | _______________________ | _____________________________________ |

## SECTION 3: Self-carry and Self-administer Medications Authorization

Is the above student deemed responsible and knowledgeable to self-carry and self-administer the following medications?

□ No. □ Yes. (If yes, please list.)_________________________________________________________________________________

Signature of Physician, CRNP or PA: ____________________________________________ Phone #: __________________________

Printed Name of Physician, CRNP or PA: ________________________________________ Date: _____________________________
(The above medication order is valid 8/01/2018 – 8/01/2019)

**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 appointed school personnel, may administer this medication during school hours or school sponsored events to this student (unless authorized to self-carry and administer). 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. I understand that **all medications will be discarded if not picked up by May 31, 2019.**

Signature of Parent: ____________________________________________________________ Date: ___________________________