United Faith Christian Academy

Christ-centered ● College Prep School ● PreK – 12th Grade

8617 Providence Road, Charlotte, NC 28277

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2020-21 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 (*for allergic 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 2019-2020 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 8/01/2019 – 8/01/2020)

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, 2020.**

Signature of Parent: _____ Date: _____