



26052 Trabuco Road, Lake Forest, CA 92630
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MEDICATION AUTHORIZATION FORM

Preschool through Jr. High

Your enrollment packet indicates that medication may need to be administered to your child for his/her well-being while here at school. In order for us to store and/or administer this medication, **you and your physician** will need to complete the following information and **return it to the School Office** prior to the first day of school, with the actual medication (inhalers included), in its original container with the prescription label on it.

For the safety of all our students, please be aware that we cannot allow any medication to come to class with your child or be kept in his/her bag while in school. All medication must be checked in through the School Office.

(Please detach and return to the school office prior to the first day of school)

GRACE CHRISTIAN SCHOOLS – MEDICATION AUTHORIZATION

My child is attending GCS: Preschool / Elementary / Jr. High

Physician Statement of Need (To be completed by Physician)

Student Name: _____

Medication: _____

Dosage: _____

Time/interval dosage given: _____

Date to begin dosage: _____

Date to stop dosage: _____

Possible adverse reactions: _____

Possible severe reactions: _____

Instructions for storage: _____

Place Physician's Stamp Here

Physician's Signature

Date

Medication Administration Release (To be completed by parent or guardian)

Student Name: _____

Birthdate: _____ Session: _____ Room: _____

Parent's Name: _____

Medication: _____

Dosage: _____

Time/interval dosage given: _____

Date to begin dosage: _____

Date to stop dosage: _____

I request that Grace Christian Schools be allowed to administer the above medication to my child in accordance with my request and the Physician's Statement of Need. I will notify the school in writing of changes in my child's condition with respect to the administration of medication, or with changes to the information provided on this form. I understand that it is my responsibility to send an appropriate supply of medication to the school in its original container. Medication provided to the school in any container other than the original will not be accepted. I also understand that the school will have limited liability while administering medication to my child in accordance with the Physician's Statement of Need. A written log of medication administered is on the reverse side of this form.

Parent Signature

Date

Please Initial & Date: Completed Form without Medication on: _____

Completed Form with Medication on: _____

End of School Year Picked up Medicine date/parent initial: _____