2019-2020 School Authorization
for Scholar to Carry a Prescription Inhaler and/or Prescription Epi-pen

Scholar Name: _____

My child (named above) needs to carry the following prescription-labeled inhaler and/or prescription-labeled Epi-pen (please circle) with him/her. The above named scholar has been instructed in the proper use of the medication and fully understands how to administer this medication. It is preferable that a second prescription-labeled inhaler and/or prescription-labeled Epi-pen be kept at the front desk in case the first is lost or left at home.

Medication	Dosage	Directions

_____ _____

Physician's Signature or Stamp Physician's Phone Number

Date: _____

I have been instructed in the proper use of my prescription-labeled medication and fully understand how to administer this medication. I will not allow another scholar to use my medication under any circumstances. I also understand that should another scholar use my prescription, the privilege of carrying my medication may be revoked. I also understand that I have the responsibility of checking in with the office in case I start having problems with my medication.

_____ _____

Scholar Signature or Parent Signature *(if under 12 years old)* Date

I hereby request that the above named scholar, over whom I have legal control, be allowed to carry and use the prescription medication described above at school. I accept legal responsibility should the above medication be lost, given, or taken by a person other than the above named scholar. I understand that if this should happen, the privilege of carrying the medication may be revoked. I release Arlington Christian School, the Board of Trustees, and its employees of any legal responsibility when the above named scholar administers his/her own medication.

_____ _____

Parent/Guardian Signature Date

2019-2020 School Authorization to Give Medication at School

If medication can be given at home please do so; however, if medication must be given during school hours, this form must be completed.

Scholar's Name: _____

Teacher: _____ Grade: _____

I understand that for Arlington Christian School's office staff to administer medication to my child during school hours is done so as an accommodation for my convenience and that Arlington Christian School does not employ a full-time nurse. I understand that it is the responsibility of my child to report to the office for his/her medication and agree that I will not hold Arlington Christian School responsible for my child not taking his/her medication. With this understanding, I hereby request that Arlington Christian School, through the director or designee, supervise/assist in the administering of medication to my child according to instructions on the medication label. I understand that:

- Prescription or non-prescription medications **MUST** be held for my child in the school office (other than an inhaler) and not held by my child or held in the classroom.
- Medications **must** be in the original labeled container (no baggies, foil, etc.)
- Parent/Guardian must provide specific written instructions, as well as the medication and related equipment, to the director or designee.
- It will be the responsibility of the parent/guardian to inform the school of any changes. New medication or new doses will not be given unless a new form is completed.
- All medication will be taken directly to the office/clinic by the parent.
- I will provide only the quantity of medication that is necessary for the number of days specified by the physician and that any unused medication will be disposed of unless picked up within one week after school dismisses.
- It is the responsibility of the parent/guardian to ensure that medication has not expired.

Name of Medication: _____

Physician Name: _____ Physician Phone: _____

I release Arlington Christian School, the Arlington Christian School Board of Trustees, and any school employee from any liability for administering this medication.

_____ _____

Parent/Legal Guardian Signature Date

Home Phone: _____ **Work Phone**: _____ **Cell**: _____

To be completed by physician for prescription medications given for more than two weeks.

Condition/Illness requiring medication: _____

Possible side effects if any: _____

_____

_____ _____

Signature of Physician **Date**