GREATER PORTLAND CHRISTIAN SCHOOL

Authorization to Administer Medication During School Hours

For School Year:_____

Student Name: _____ Grade: _____

Name of Medication:_____

Medication Description (e.g., tablet, drops, inhalant): _____

Dosage: _____

_____

Time to be given:_____

Healthcare Provider's Name:_____

Healthcare Provider's Phone:_____

Reason for Medication: _____

_____

Possible side effects and safety procedures:_____

_____

Parent Authorization for Medication Administration: I authorize medically unlicensed GPCS staff to administer the above medication to my child as stated. I understand that if the medication is still in school seven (7) days after the last student day, the medication will be disposed of.

Parent/Guardian Signature:_____ Date:_____

Parent/Guardian Name Printed:_____