NORTHPOINT CHRISTIAN SCHOOL

Authorization for Administration of Medications

Nursing office: 662-349-5128, **Fax 662-349-4962**

Name of Student:_____Grade:_____Birth Date:_____Date:_____

Medication Allergies:_____

Name of Medication:_____ Dose:_____

Route to be administered:_____

Time to be given:_____

Reason medication is given:_____

If medication is to be given as needed, please describe

symptoms_____

Discontinuation Date:_____

Authorization by Parent/Guardian:

I hereby request that the school nurse administer the above medication. I understand that I **must** supply the school with the original prescription container (label intact) or the non-prescription container in compliance with the Northpoint Christian School Medication Policy.

Is the student physically and mentally able to self-administer the medication with assistance? YES__ NO__

The undersigned hereby certifies that the cooperation of the school personnel in assisting with this medication is necessary in order to permit the student to maintain regular school attendance. The undersigned agrees to release, indemnify and hold harmless Northpoint Christian School and its employees from any claim, liability or expense arising out of or in any way connected with the giving or failure to give prescribed medication to my child. This release and indemnity agreement includes claims based on alleged negligence on the part of Northpoint Christian School or its employees. I agree that it is my responsibility to inform the school nurse, in writing of any change in medication and/or its distribution to my child.

Parent/Guardian Name :(print) _____Emergency Phone Number:_____

Parent/GuardianSignature:_____Date:_____

Physician's Signature:_____Date:_____