Columbus Academy

COLUMBUS ACADEMY AUTHORIZATION FOR PRESCRIBED MEDICATIONS

Student name: _____

Grade: _____

Date of Birth: _____

Name and Dose of Medication: _____
*this includes all rescue medications, medications for ADD/ADHD, and any other prescribed medication from your physician that your child would need to take at school

Amount to be Administered and Route: _____

Time to be Administered: _____

Special Instructions: _____

Please indicate if student will carry **rescue** medication in backpack: Yes / No

Date to Begin: _____ Date to End: _____

Print Physician Name: _____

Physician Signature: _____

*I request that the drug prescribed by the physician be administered to the student. I agree to submit in writing a revised physician's statement in the event that any of the required information should change. I give permission for the school nurse to contact the physician regarding administration of this medication. I agree to deliver the medication in its original container with all the proper information clearly legible. Please fax to 614-509-2687

Print Parent/Guardian Name: _____

Signature and Date: _____