EBENEZER
CHRISTIAN SCHOOL

Physicians Authorization for the Administration of Medication at School

Student_____ Birthdate_____

This portion to be completed by the student's physician:

Medication will be given to a student at school only when absolutely necessary. The parent and legal prescriber are urged to design a schedule for giving medication outside of school hours. If this is not possible, designated school employees will dispense the medication.

The school accepts no responsibility for untoward reactions when the medication is dispensed in accordance with the directions of the student's physician.

Name of Medication:_____Generic Name:_____

Dosage:_____Time(s) of Dosage:_____

Reason Medication Must be Given:_____

Anticipated Action of Medication:_____

Other Instructions:_____

Length of Prescription Period: From_____To_____

Possible Side Effects:_____

Emergency Measures in Case of Serious Side Effects:_____

I certify that valid health reasons exist requiring that the medication be administered during the school hours or during such a time that the student is under supervision of school officials.

I request and authorize that the above named student be given the above-identified medication in accordance with instructions indicated.

_____ _____

Date of Signature Physicians Signature

Telephone#_____ _____

Name (Print or Type)

Please send completed form to:

Ebenezer Christian School 9390 Guide Meridian Rd. Lynden, WA 98264 (360) 354-2632