Authorization to Dispense Medicine

Calvary Christian High School

Medication Administration

Last Name
First Name

ADMINISTRATION OF PRESCRIPTION OR OVER-THE-COUNTER MEDICATION School Year _____

All medication must be in the labeled prescription or over-the-counter original container

Name of Medication	Prescribed for (reason)	Dosage	Instructions

I give my permission for Calvary Christian High School to administer the above medication to my son/daughter.

_____

Signature of Parent/ Legal Guardian Date Daytime Phone

Date	Time	Name of Medication	Reason	Signature of Person Administering Medication