THREE RIVERS CHRISTIAN SCHOOL

2610 Ocean Beach Hwy
Longview, WA 98632
360-423-4510 Fax 360-423-1180

Medication Authorization Form

Student Name: ____________________________ DOB: ____________

Grade: ____________ Phone Number: ___________________

THIS PORTION TO BE COMPLETED BY PHYSICAN/DENTIST

Medication Name	Dosage	Method of Administration	Time
_________________________	__________	____________________	__________
_________________________	__________	____________________	__________
_________________________	__________	____________________	__________

If given PRN specify length of time between dosages: ______________________

Inhalers: ______________________

Please indicate if student MUST carry on his/her person __________ Yes __________ No

Student is capable to self-administer medication __________ Yes __________ No

Possible side effects of medication ____

Emergency procedure in case of serious side effects ____

I request and authorize tat the above named student be administered the above identified medication in accordance with the instructions indicated above from ______________ to ______________ (not to exceed the school year) as there exists a valid health reason which makes administration of the medication advisable during the school hours.

____________________ ____________________________________

Date Physician/Dentist Signature

____________________ ____________________________________

Phone # Printed Name

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I request/authorize the school to administer medication to the student I accordance with the doctor's instructions for the period from ______________ to ______________ (not to exceed current school year). I understand that every effort will be made by the school staff to administer the medication in a timely manner.

____________________ ____________________________________ ____________________

Date Parent/Gaurdian signature Phone #