



# West-Mont Christian Academy

873 South Hanover Street • Pottstown, Pennsylvania 19465  
610-326-7690

## AUTHORIZATION FOR SCHOOL MEDICATION ADMINISTRATION

Child's Full Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Allergies: \_\_\_\_\_

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I, the parent/guardian of \_\_\_\_\_ request that the employees (nurse, principal, or designee) of West-Mont Christian Academy administer the above named medication. My signature on this document constitutes a complete waiver of liability claim in any and all respects against West-Mont Christian Academy and its Board of Directors and all of its employees unless the Academy is negligent with regard to any claim for injury in connection with dispensation of the prescribed medication.

Additionally, I agree to provide the medication to the school in the original pharmacy or physician labeled container. I also accept responsibility to provide a physician's note and my written instruction if the medication is to be changed or discontinued. I give permission for the school and physician to communicate regarding this medication/medical condition.

Name of medication(s): \_\_\_\_\_

Reason: \_\_\_\_\_

Dose: \_\_\_\_\_ Route: \_\_\_\_\_

Time(s) to be given at school: \_\_\_\_\_

Medication is to be administered

\_\_\_\_\_ entire school year      \_\_\_\_\_ daily      \_\_\_\_\_ as needed

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

List all medication currently being taken by child: \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone Number