White Horse Christian Academy, LLC

"Then I saw heaven opened, and a white horse was standing there. Its rider was named Faithful and True,..." - Revelations 19:11 NLT

MEDICATION REQUEST AND AUTHORIZATION

STUDENT'S NAME:_____DOB _____

MEDICATION_____ AMOUNT _____TIME_____

Condition for which the medication is to be given and/or instructions:

_____

_____

Physician / Dentist Signature_____ Date_____

Office Number _____ Fax Number _____

Authorization is valid for one school year. The physician or dentist must be licensed to practice in the United States. Physician signature is required for controlled substances, over the counter medication, long term therapy, or changes in the original prescription.

****All medications must be in their original container and cannot be expired.****

I request and authorize White Horse Christian Academy to administer the above-mentioned medication as prescribed. I understand the school administrator may designate any qualified person or persons to administer this medication. I also understand that although a reasonable attempt will be made to remind the student, it is expected that the student will be responsible in most situations to arrive for medication. Medication doses that could be given at home will not usually be given at school. Medications for short term therapy scheduled for three times daily, may generally be given at home. All medications must be in their original container.

I also authorize the school's registered nurse (RN)/licensed vocational nurse (LVN) to consult with the prescribing physician to clarify this medication order, or in the interest of the student's health, to discuss his/her response to the prescribed medication as required by the Texas Nurse Practice Act. It is expected that the school nurse will first attempt to notify a parent /guardian should such contact become necessary.

Parent/Legal Guardian Signature _____Date _____

Day Telephone_____

Cell Number _____