

Authorization For Medication Form (AMF) High Point Christian Academy

This form shall be completed for

- prescription medication
- over-the-counter medication that is not listed on the *Over-The-Counter Medication Form*

that is to be administered by school personnel. The completed form is to be returned to the Academy office. The medication is to be hand-carried to the office by the parent/guardian in its original container or pharmacy-labeled container. Please do not send medications with the student or give any medications to teachers. Please refer to High Point Christian Academy medication policy found in the student handbook for further information (Handbooks are found on our website www.hpcacougars.org).

Student Name _____ Birth Date _____

Classroom / Homeroom Teacher Name _____

This box to be completed by physician:

Name of Medication: _____ (include generic and trade name)	
Dosage (amount to be given) _____	
Time(s) to be taken at school: _____ To be given from (date) _____ to _____	
Reason for Medication: _____	
Side effects (expected or predictable): _____	
Prescribing Physician's Name (Print): _____ Office Phone _____	
_____ Physician Signature	_____ Date

PARENT'S PERMISSION

I hereby give my permission for my child (named above) to receive medication during school hours. I understand that the school undertakes no responsibility for the administration of the medication. This medication has been prescribed by a licensed physician, and I hereby release High Point Christian Academy from any liability that may result from the prescribed medication.

Parent/Guardian Signature

Date