Grace Valley
CHRISTIAN ACADEMY

MEDICATION AUTHORIZATION FORM | K-8

Grace Valley Christian Academy is willing to make all reasonable accommodations, including assistance with required medication (prescription or over-the-counter), to allow students to attend school regularly and participate in the educational process. Any student who is required to take medication may be assisted by Grace Valley staff.

PARENT INFORMATION

- List **ALL** medication your child is authorized to take at school (backside of this form), including medication your child can carry on their person (i.e., inhaler).
- Provide all medication in its original and properly labeled container to the school office.
- All prescription medication must be in the original container and must have a current prescription label attached, which includes: student's name and the physician's directions (method, amount, and time schedule).
- Inform the school office of any changes in the medication plan.
- A new form must be completed annually.
- A new form must also be completed whenever there is a change in the following circumstances:
    - Change in medication (i.e., name)
    - Change in medication form (i.e., tablet, capsule, liquid)
    - Change in medication dose (amount)
    - Change in medication time given
- The table below identifies which medications must be stored in the school office and which can be carried on the student for self-administration.

GRADES	PRESCRIPTION	OVER-THE-COUNTER	EPI-PEN	INHALER
K-3	Office	Office	1. Office 2. Classroom *(optional)*	Office
4-8	Office	Office	1. Office 2. Student *(optional)*	Student

I, the undersigned, am the parent/guardian of the student named on the backside of this form, request and authorize the staff at Grace Valley Christian Academy to assist with the administration of my child's medication at school. The medication I am providing is in the original container, and all prescription medication includes physician's directions on the container. I agree to hold Grace Valley Christian Academy harmless from any and all liability resulting from assisting the student with medication in the manner directed.

Parent/Guardian Signature _____ Date _____

Print Name _____

MEDICATION INFORMATION

*List **ALL** medication your child is authorized to take at school, including medication your child can carry on their person (i.e., inhaler).*

STUDENT NAME _____ **GRADE** _____

1) MEDICATION _____ DOSE _____

FREQUENCY _____ TIME _____

REASON FOR MEDICATION* _____

Medication will continue for _____ days or until _____

Observable adverse reactions/possible side-effects _____

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2) MEDICATION _____ DOSE _____

FREQUENCY _____ TIME _____

REASON FOR MEDICATION* _____

Medication will continue for _____ days or until _____

Observable adverse reactions/possible side-effects _____

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3) MEDICATION _____ DOSE _____

FREQUENCY _____ TIME _____

REASON FOR MEDICATION* _____

Medication will continue for _____ days or until _____

Observable adverse reactions/possible side-effects _____

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4) MEDICATION _____ DOSE _____

FREQUENCY _____ TIME _____

REASON FOR MEDICATION* _____

Medication will continue for _____ days or until _____

Observable adverse reactions/possible side-effects _____

Additional remarks/directions _____

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*NOTE: Give all reasons a medication can be taken for (i.e., Advil – headache, cramps, inflammation, etc.).