THE KING'S ACADEMY

1015 S. Ebenezer Road Florence, SC Phone 843. 661.7464 Fax 843. 661.7647

www.tkaflorence.com

Prescription Medication Permission Form

Student: _____DOB_____Grade_____

Teacher: _____

MUST BE COMPLETED BY PHYSICIAN OR AUTHORIZED HEALTHCARE PROVIDER

Name of Medication: _____

Dosage: _____Time to be given: _____

Reason for Medication:_____

Restriction and/or Side Effects:_____

Healthcare Provider's Signature:_____Date:_____
Address:_____Phone:_____

TO BE COMPLETED BY THE PARENT/GUARDIAN

We, the undersigned parents of the above named child, request that the medication we have delivered to the school in the original container be administered as prescribed.

The school nurse has our permission to contact the doctor for verification of this information or for clarification of any matter relative to the above. I give permission for the health care provider named above or his/her employees to share information about the medication and my child's health with the school nurse or the principal.

We do further agree to save harmless any school personnel who administer or attempts to assist with the above medication in the manner described. This shall mean we agree not to sue school personnel who administer or attempt to assist with the medication in the prescribed manner, either civilly or criminally, for injury resulting from administering or attempting to assist with the above described medication.

Parent/Guardian Signature:_____Daytime phone #_____

Minds and Hearts Coming Fully Alive in Christ!