



DATE: _____

TEACHER: _____

GRADE: _____

HOUSTON ACADEMY

Lower School

Medication Authorization Form

Medication may only be given to your child when a current form is completed and the parent provides the medication. No over the counter medication will be administered to Lower School students unless the student's parent or guardian provides it.

Student Information

Student Name: _____

Any known allergies/reactions: _____

Prescription Medication Authorization

Prescribing Physician: _____ Name of medication: _____

Reason for taking: _____ Strength: _____ Dosage: _____

Date(s) to be given: _____ Time(s) to be given: _____

Parent Signature _____

Nonprescription Medication Instructions

Name of medication: _____ Dosage: _____

Reason for medication: _____

Date(s) to be given: _____ Time(s) to be given: _____

Parent Signature: _____ Phone Number: _____

Parent Authorization and Release

I authorize such school personnel as may be designated by the administration to assist my child in taking the above medication.
I understand that additional signed authorization will be necessary if the dosage of the medication is changed.

I acknowledge that the medication must be registered with the school counselor or her designee. It must be in the original container and properly labeled with the name of the student, name of physician, name of medication, date of prescription, strength, dosage, and the date of the drug's expiration when appropriate. I understand that school personnel will properly discard any unused medication which expires or is not picked up by the parent by the end of the current school year.

I hereby release Houston Academy, its administration and employees from any and all liability, of any nature and character, which may be alleged to arise out of or relating to the administration of the medication described above, provided such administration is in substantial conformity with the above instructions.

Parent Signature _____ Date: _____