HARVEST
CHRISTIAN ACADEMY
Shaping extraordinary futures

AUTHORIZATION FOR ADMINISTERING MEDICATION

STUDENT_____ DATE _____

GRADE _____ TEACHER _____ AGE _____

Name of Medication _____ Allergies _____

Ordered frequency _____ Dosage _____

Dates to be taken at school _____Time to be taken _____

Reason for Medication _____

Special Instructions _____

Parent's Authorization:
I authorize HCA staff to administer the above medication to my child.

_____

Parent's Name (Print) (Sign) Date

RECORD OF ADMINISTRATION

DATE	TIME	DOSE	ADMINISTRATOR