HARVEST
CHRISTIAN ACADEMY

AUTHORIZATION FOR ADMINISTERING MEDICATION

STUDENT NAME _____ AGE _____

GRADE_____ TEACHER_____

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) (Signature) Date

Date	Time	Dose	Administration