Y O U N G A C A D E M Y

PHYSICIAN ORDER FOR PRESCRIPTION MEDICATION AT SCHOOL

Please complete one for each medication each academic year.

SCHOLAR'S NAME _____ DATE OF BIRTH_____

MEDICATION_____ _____ DOSAGE_____TIME TO BE TAKEN___ _____

DATES TO BE TAKEN_____ DATE D/C_____

FORM: ☐ Tablet ☐ Capsule ☐ Liquid ☐ Inhalant ☐ Topical ☐ Other: _____

Condition for which medication is to be taken_____

Please contact me if the following symptoms occur: _____

_____

☐ **I hereby grant E.A Young Academy authorized staff permission to administer this medication.**

PHYSICIAN'S NAME (Print) _____OFFICE PHONE NUMBER:_____

ADDRESS:_____CITY_____STATE_____ZIP_____

PHYSICIAN'S SIGNATURE_____ DATE_____

PARENT/GUARDIAN USE ONLY

☐ I hereby grant permission for my daughter/son to take medication at school, as ordered, and authorize academy personnel to contact my child's physician if necessary.

☐ I agree to provide the school with the medication in its original, properly-labeled container.

☐ I agree to notify the school, in writing at the termination of this request or when any change in medication is necessary.

☐ I agree to release E.A. Young Academy from any and all liability claims arising from the administering of this medication at school.

PARENT/GUARDIAN SIGNATURE_____DATE_____