Cornerstone Christian Academy

Medication Authorization Form for Prescription

Student's Name:_____

Date of Birth:_____

Allergies to Medications:_____

Name of Medication:_____

_____Tablets or Teaspoons (circle one) to be given every _____ hours

For what condition:_____

Physician Name:_____

Physician Phone:_____

I request school staff to administer the medication as described above and prescribed by my child's primary prescriber. I consent to medication administration for my child named above and agree to review and provide special instructions for the administration of the medication to the school staff. I understand that Cornerstone Christian Academy, the Board, and its employees are not liable for damages or injuries resulting from administration of medication to my child in accordance with Texas Education Code 22.052.

_____ _____

Parents Name (Printed) Relationship to child

_____ _____

Parent/Guardian Signature Date

All signed forms will be valid for one school year. Changes in dosage require a new form. Medication must be delivered to the school by the parent/legal guardian, in the prescription container with the current date.