ARISTOI CLASSICAL ACADEMY

AUTHORIZATION TO ADMINISTER MEDICATION AT SCHOOL

PLEASE DO NOT SEND MEDICATION WITH YOUR STUDENT!

Please complete the following if the medication named below is to be given during school hours in order to keep this child in optimal health and help maintain school performance. ALL MEDICATIONS MUST BE IN THEIR ORIGINAL CONTAINER AND TURNED IN AT THE FRONT OFFICE BY A PARENT/GUARDIAN.

NAME OF STUDENT: _____ GRADE: _____ TEACHER:_____

Diagnosis or Reason for Medication: _____

Name of Medication: _____ Expiration Date _____

Dosage and Time: _____

Common Side Effects: _____

Medication Usage: ☐ As Needed

(Check all that apply) ☐ From :_____(mm/dd/yy) To: _____(mm/dd/yy)

Physician Section Required For Prescription Medications.

PHYSICIANS: Please sign and return this authorization form to the parent or the school as soon as possible.

_____

Physician's Name (print or type) Physician's Signature

_____

Telephone Number Fax Number

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PARENTS: *I hereby give permission for Aristoi Classical Academy to administer the medication listed above to my child, as requested by me or the above physician.*

_____

Parent's Signature Date

_____

Telephone Number Fax Number

ARISTOI CLASSICAL ACADEMY **Phone:** 281.391.5003 **Fax:** 281.391.5010