MOUNT PISGAH
CHRISTIAN SCHOOL

Authorization for NON-PRESCRIPTION Medication/Treatment

Student's Name: _____ Grade: _____

Name of Medication/Treatment

_____

Dosage of Medication _____ or Description of Treatment _____

Time the Medication/Treatment is to be given during the school day: _____

Specific days/dates the Medication or Treatment are to be given: _____

Does this student need assistance to administer the medication/treatment?:

YES / NO (circle one)

If yes, please explain: _____

_____

I hereby request that Mount Pisgah Christian School, through its designated authority supervise/assist in the administering of medication to my child, _____ according to the instructions contained on this form.

I release the school, and any employee, from any liability for administering this medication.

Parent/Guardian Signature: _____ Date: _____

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