MOUNT PISGAH
CHRISTIAN SCHOOL

Authorization - PRESCRIPTION Medication/Treatment

Student's Name: _____ **Grade:** _____

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 the physician's statement.

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

Parent/Guardian Signature _____ Date _____

PHYSICIAN'S STATEMENT

NAME OF MEDICATION _____

DOSAGE _____

Time medication is to be given during the day: _____

Expected duration of administration of medicine: _____

Possible side effects, if any: _____

_____

Suggested basic first aid procedures for handling possible side effects:

_____

Is this student in need of assistance in administering this medicine? YES NO

If YES, explain assistance needed: _____

Physician Signature

Signature Date

Physician Name (PLEASE PRINT)

Physician's Phone Number

Physician Address

Mount Pisgah Christian School
9820 Nesbit Ferry Road
Johns Creek, GA 30022
Phone: 678-336-3300 FAX: 678-336-3349