LONGVIEW CHRISTIAN ACADEMY
Medical authorization

Student's Name _____

In case of minor headache or discomfort, do we have permission to administer: (please circle one)

Aspirin: Yes or No Non-aspirin: Yes or No Pepto Bismol: Yes or No

Please list any allergies your child has:
_____

To be completed by the child's parent(s)/guardian(s). **A new form must be completed every school year.** To be kept in the school office.

Birth Date:_____
Address:_____
Father's Cell: _____ Mother's Cell:_____
Physician's printed name:_____
Office Address:_____
Office Phone:_____

*If applicable, please fill with the necessary information below:

Prescription medication name: _____
Purpose:_____
Dosage:_____ Frequency:_____
Time medication is to be administered or under what circumstances:
_____
Prescription Date: _____ Order date: _____ Discontinuation Date: _____
Diagnosis requiring medication: _____
Is it necessary for this medication to be administered during the school day? Yes No
Expected side effects, if any: _____
Other medications student is receiving: _____

If more than one prescription, fill on a seperate sheet of paper

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(continue)

For all parents/guardians:

By signing below, I agree that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize the Longview Christian Academy, in my behalf, to allow my child to self-administer, while under the supervision of the Academy, lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse and specifically consent to such practices, and

I agree to indemnify and hold harmless Longview Christian Academy against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self-administration of medication.

_____ _____
Parent/Guardian Printed Name Date

_____
Parent/Guardian Signature Name

For only parents/guardians of students who need to carry asthma medication or an EpiPen®:

I authorize Longview Christian Academy to allow my child to possess and use his or her asthma medication and/or epinephrine auto-injector: (1) while in school, (2) while at a school-sponsored activity, (3) while under the supervision of school personnel, or (4) before or after normal school activities, such as while in before-school or after-school on school-operated property. Texas law requires the Academy to inform parent(s)/guardian(s) that it incurs no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-administration of medication or epinephrine auto-injector.

If you agree, please initial: _____ Parent(s)/guardians(s)