Calvary CHRISTIAN ACADEMY

Medication Action Plan

School Year _____ - _____

This form must be completed fully in order for our school to administer the required medication. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of a medication.

- All medications must be in original container with the label intact
- Medication must be dropped off to the nurse by the parent/guardian
- First dose of medication must be given at home

Prescriber's Authorization

Name of Student: _____ DOB: _____Grade: _____

Condition for which medication is being administered: _____

Medication/Strength: _____Dose: _____ Route: _____

If PRN, for what symptoms: _____

Relevant side effects: ☐ None expected ☐ Specify: _____

Medication shall be administered from: _____ to _____

Month/Day/Year Month/Day/Year

EpiPen, inhaler, insulin: student is responsible to permit self-carry/administration? ☐yes ☐no

Is this medication required during field trips? ☐yes ☐no

Prescriber: _____ Address: _____

Signature: _____ _____

_____

Authorization by Parent/Guardian for the administration of the above medication by school personnel:

I request that the above medication, ordered by my child's medical provider, be administered during the school day. I understand that I must supply any medication in the original container. I understand that this medication will be destroyed if it is not picked up within three days following termination of the order or beyond the end of the school year. Parent permission for student self-carry/administration of emergency medication such as EpiPen, inhaler, basqimi ☐yes ☐no

Trained designee is given permission to supervise/assist/administer in prescription medication administration in the absence of a school nurse ☐yes ☐no

I understand that Calvary Christian Academy may not be held liable for reactions for medication administered per prescription directions and at the request of the parent/guardian.

Parent/Guardian: _____Signature: _____

Order reviewed for safe implementation ☐ Nurse: _____ Date:_____