livingwater CHRISTIAN SCHOOL

MEDICATION AUTHORIZATION FORM

I hereby give permission to Livingwater Christian School to administer the following medication to my child according to the specific directions stated below:

CHILD'S NAME:_____
DATE OF BIRTH:_____/_____/_____
SYMPTOMS:_____

BEGINNING DATE OF ADMINISTRATION:____/____/_____
ENDING DATE OF ADMINISTRATION:____/____/_____

NAME OF MEDICATION:_____

METHOD OF ADMINISTRATION: (CIRCLE ONE)
ORAL TOPICAL INJECTION OTHER_____

AMOUNT TO BE ADMINISTERED:_____
TIMES TO BE ADMINISTERED:_____AM/PM_____AM/PM

PARENT/GUARDIAN SIGNATURE:_____DATE:_____

MEDICATION ADMINISTRATION LOG

DATE:	TIME:	INITIALS:	DATE:	TIME:	INITIALS:

LIVINGWATER CHRISTIAN SCHOOL
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