



Salem Christian Academy  
Authorization for Administration of  
**Over the Counter/Prescription/Emergency Medications**

**TO BE COMPLETED BY PARENT/GUARDIAN:**      DATE OF REQUEST: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Grade: \_\_\_\_\_ DOB: \_\_\_\_\_

I give permission for my child (named above) to be given the medication as indicated. I am aware that non-medical personnel will be administering this medication to my child. I hereby release Salem Baptist Church, SCA school administration, their agents and employees from any and all liability that may result from my child taking the medication.

\_\_\_\_\_  
Parent/Guardian Name (Print)

\_\_\_\_\_  
Parent/Guardian Signature

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**TO BE COMPLETED BY PHYSICIAN: (Only one medication per sheet)**

It is necessary that the above named child receive the following medication during the school day. Please administer the following as prescribed below:

Circle the type of medication:   Prescription      Emergency/Rescue      Over-the-Counter

Name of Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Time to be Given: \_\_\_\_\_ Route to be administered: \_\_\_\_\_

Circle form of medication:   Tablet   Capsule   Liquid   Ointment   Inhalant   Other \_\_\_\_\_

Emergency Medications (**ONLY** inhalers, Epi Pens, Glucagon, and Valtoco nasal spray) may be kept in the classroom with the student or may be kept by the student.

Yes \_\_\_\_\_ No \_\_\_\_\_

Precautions/Side Effects/Comments \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Address: \_\_\_\_\_