

FIRST ASSEMBLY CHRISTIAN SCHOOL  
8650 WALNUT GROVE ROAD  
CORDOVA, TENNESSEE 38018  
TELEPHONE: 901-458-5543  
FAX: 901-324-3558

## AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS

**Please Complete All Information:**

**Date:** \_\_\_\_\_

Student Name: \_\_\_\_\_ Approximate Weight: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Grade: \_\_\_\_\_ Academic Year: \_\_\_\_\_

Diagnosis for which medication is given: \_\_\_\_\_  
i.e. Behavioral, seizure, asthma, diabetes

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

Form (pill, liquid, inhaler): \_\_\_\_\_ How often to be given? \_\_\_\_\_

List significant side effects: \_\_\_\_\_

Note any special considerations while on this medication: \_\_\_\_\_

Termination Date for Administering Medicine: \_\_\_\_\_

**The undersigned hereby verifies that the cooperation of school personnel in assisting with this medication is necessary in order to permit the student to maintain regular school attendance.**

\_\_\_\_\_  
Physician's Signature (prescription drugs only)

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date

**I request that my child be allowed to take his/her medication as authorized by the physician and me. I understand although a reasonable attempt will be made to remind the student, it is expected that the student will be responsible for obtaining his/her medication.**

**First Assembly Christian School will not administer medication to any student who does not have this form on file in the school office.**

Emergency  
Information:

Mom's Cell Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Home: \_\_\_\_\_

Dad's Cell Phone: \_\_\_\_\_ Work: \_\_\_\_\_

Place of Employment - Mom: \_\_\_\_\_ Dad: \_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_

\_\_\_\_\_  
Emergency Contact Name & Relationship