New Heights Academy  Medication Release Form

Student's Name	
Address	
City, State, Zip	
County	

Medication Name:	
Dosage:	
Frequency:	
Time of Day:	
Additional Information	

All prescription medication requires original pharmaceutical container along with attending physician's name, medication name, dosage, and child's name. Attending physician must sign this form with acknowledgment that the student information above is under their care and such medication is prescribed.

I authorize the staff at New Heights Academy to administer the above medication per my instructions. It is my responsibility to submit in writing any changes to my child's supplement regimen. The staff will follow this authorization only until another is submitted in writing by parent(s) and physician.

Parent Name	Date: MM/DD/YYYY	Signature
Physician Name	Date: MM/DD/YYYY	Signature