PROVIDENCE CHRISTIAN ACADEMY

2023-2024 NON-PRESCRIPTION MEDICATION AUTHORIZATION FORM

Student Name: _____ Grade:_____

Birthdate:_____

Allergies (Medications): _____

_____

_____

As parent/guardian of the above named student, I request that PCA staff to give medicine for the following condition(s) This medication request must be deemed necessary to maintain or improve health and participation in the school program. Each request will be assessed for the most appropriate intervention and **will be given at the standard dosage recommended by the manufacturer**. *(Check all that Apply)*

CONDITION: ___Headache ___Cramps ____Dental ____Other:_____

MEDICINE: ___Acetaminophen (Tylenol) _____Ibuprofen (Motrin) ____Midol/Pamprin

___Tums _____Pepto Bismol ____ Other

Dose:_____ Frequency:_____(if less than manufacturer's recommended dose)

Specify Time:_____ OR As Needed:_____

Special Instructions for Administration:_____

I understand that the school, Providence Christian Academy, is not legally obligated to administer medication to my child. Therefore, I agree to defend and hold harmless, the school and its employees from any liability for the results of the medication or the manner in which it is administered, and to defend and indemnify the school and its employees for any liability arising out of these arrangements. I understand that in the absence of the school secretary, other trained school staff will administer the medication. I will notify the school secretary if I give this medication to my child before arriving at school while this request is in effect to prevent overmedicating. I also affirm that my child has taken medicine at least two times in the past without any adverse side effects. I understand any medication I supply will not be kept by the school over the summer break per DEA regulations.

Parent/Legal Guardian Signature:_____

Printed Parent/Legal Guardian Name:_____Date:_____