



**Permission to treat a Minor without a Parent/Guardian  
& Non-Prescription Medication Authorization Form**

Academic Year \_\_\_\_\_

**Student Name:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

Providence Christian Academy (PCA) must receive permission from the student's parent or legal guardian before providing treatment for an injury or illness that is non-life threatening. This form gives our staff your consent to assess and treat your student without an accompanying adult present.

**Specifically, I consent to each of the following services below:**

<input type="checkbox"/> Simple first-aid treatment (bumps, bruises, and scrapes, etc.)	<input type="checkbox"/> Dispensing of non-prescription medications
<input type="checkbox"/> Management of chronic maladies such as asthma	<input type="checkbox"/> Simple conflict resolution with staff or peers
	<input type="checkbox"/> Simple counseling in the event of emotional duress

As parent/guardian of the above-named student, I request that PCA staff administer medicine for the following condition(s). This medication request must be deemed necessary to maintain or improve health and participation of the students in the school's programs. 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: \_\_\_\_\_

Dosage & Frequency: (if less than manufacturer's recommended dose)

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Special Instructions for Administration:

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Allergies (Medications):

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I do hereby state that I am the parent and/or legal guardian of the minor student named above, who resides with me at the address on file. Under the advice and care of a PCA staff member, I consent to any necessary examination or treatment for my/our student. I understand that Providence Christian Academy is not legally obligated to administer medication to my student. Therefore, I agree to defend and hold harmless the school and its employees from any liability for the results of the medication or the way 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 medicines approved above 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: \_\_\_\_\_