

**Hillman Christian Academy**  
**2025-2026 MEDICATION AUTHORIZATION**

**Authorization for medical interventions to be administered by school personnel:**

**To be completed by the parent or physician:**

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Grade: \_\_\_\_\_

Allergies: \_\_\_\_\_

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Name of Medication	Dose	Form (tablet, liquid, etc.)	Time(s) to be administered

Reason for medication: \_\_\_\_\_

Special instructions: \_\_\_\_\_

Start:         date form received                      other start date: \_\_\_\_\_

Stop:         end of school year                      other stop date: \_\_\_\_\_

Restrictions and/or possible side effects: \_\_\_\_\_

Special storage requirements: \_\_\_\_\_

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

& Address: \_\_\_\_\_

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I hereby request that Hillman Christian Academy provide the above ordered medication to my child, \_\_\_\_\_ . I will not hold the school personnel responsible for complications related to this intervention. Any change in the procedure/medication will be accompanied by an updated statement.

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

\_\_\_\_\_  
Date

FOR OFFICE USE ONLY Date form received: _____
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