COVENANT SCHOOLS
MEDICATION AUTHORIZATION

- All medications must be in the original container
- One medication per form
- Please print clearly

MONTH _____DAY_____YEAR_____ Class_____

Child's Full Name: _____Date of Birth:_____

Prescription Name: _____Dosage:_____

Dates to be Given: Begin: _____ End: _____

Time of Day Medication is to be Given: 1._____2._____3._____4._____

Time Parent Gave Last Dose: _____Medication Expiration Date:_____

Is your child taking any other medications at the present time? ☐ YES ☐ NO

If yes, name of medication: _____

I authorized the staff of Covenant Schools to administer the above-described medication to my child in the manner described above and release Covenant Schools and the staff from any liability resulting from the administration of the above-described medication.

Parent Signature: _____

Medication Log
School Record of Times Medication was Dispensed

Dosage	Date	Time	Staff Signature (not initials)	Parent Initials