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Parkway Christian School

Authorization for Medications

No medication shall be given by PCS staff without the signed permission of a parent or guardian

Please Complete This Form and Sign

Date: _____

Child's Name _____

Name of Medication _____

Amount of Medication to be given

_____

Time Medication is to be given

_____

Parent or Guardian Signature:

_____

Clinic Use Only:

Date/Time/Amt/Initials_____ Date/Time/Amt/Initials_____

Date/Time/Amt/Initials_____ Date/Time/Amt/Initials_____

Date/Time/Amt/Initials_____ Date/Time/Amt/Initials_____

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Date/Time/Amt/Initials_____ Date/Time/Amt/Initials_____

Date/Time/Amt/Initials_____ Date/Time/Amt/Initials_____

Date/Time/Amt/Initials_____ Date/Time/Amt/Initials_____

If clinic supplies are used, a $2.00 fee will be charged for the second and additional times.

Date(s) used_____

Office use only

Entered in Rediker
Date/Initials_____