GRACE CHRISTIAN SCHOOLS OF PASCO

9403 Scot Street
Hudson, Fl 34669
Office: 727-863-1825

MEDICATION RELEASE FORM 2023-24

Name of Student _____ Date of Birth _____

Address _____
Street City State Zip

OVER THE COUNTER MEDICATION: PLEASE PUT A CHECK MARK BESIDE EACH AUTHORIZED MEDICATION. ALL MEDICATIONS MUST BE PROVIDED BY PARENTS/GUARDIANS. GRACE CHRISTIAN SCHOOL WILL NOT PROVIDE THESE MEDICATIONS.

	Medication Name	Dosage	Comments/Specifications
	Acetaminophen		
	Ibuprofen		
	Cough Drops		
	Benadryl/Generic		
	Midol/Generic		
	Topical Benadryl/Anti-itch		
	Other:		

FOR PRESCRIPTION MEDICATION: ATTACH A COPY OF THE PHYSICIAN PRESCRIPTION

A written statement must be received from the licensed prescriber detailing the method of taking the medication, the dosage and the time schedule to be observed. Medication must be delivered to the school by the parent or guardian and must be in an appropriate container that is properly marked by the pharmacy or manufacturer.

	Medication Name	Dosage	Duration

I/we hereby authorize the personnel of Grace Christian School to administer the above-named medication(s) as needed by my child(ren).

I/We hereby agree to indemnify and hold forever harmless Grace Christian School of Hudson, Fl, the administration and its officials, agents and employees against loss from any and all claims, demands, or actions in lay or in equity that may hereafter at any time be made or brought by said minor or by anyone on behalf of said minor for the purpose of enforcing a claim for damages on account of any injuries or loss sustained in consequence of the aforesaid assistance, and I/We do hereby waive any and all right of exemption, both as to real and personal property, to which we may be entitled under the laws of this or any other state as against such claim for reimbursement or indemnity.

Please read the above carefully before signing. No child will be assisted in taking medication until this form has been signed and delivered to the school.

_____ _____
Parent/Guardian Signature Date Contact Number

_____ _____
Parent/Guardian Signature Date Contact Number

STUDENT MEDICAL INFORMATION

*Please PRINT all information other than required signature.

STUDENT NAME _____ Grade: _____ School Year _____
(**PRINT**) Last Name First Name

ADDRESS: _____
Street City State / Zip

ADDRESS: _____
Street City State / Zip

Social Security No. _____ (required for treatment by emergency personnel)

Parent/Guardian _____

Mother's Contact No. _____ Father' s Contact No. _____

MEDICAL TREATMENT AUTHORIZATION:

_____ _____
Mother's/Guardian Signature Date Father's/Guardian Signature Date

If parent or guardian cannot be reached, contact:

Name _____ Phone_____

MEDICAL HISTORY:

ALL KNOWN ALLERGIES (BE SPECIFIC):

_____
_____
_____
_____
_____
_____
_____

CONDITIONS: (ANY medical condition(s) of which we should be aware)

_____
_____
_____
_____

DOCTOR'S NAME: _____ PHONE NUMBER _____

Daily Required Medications:

Name	Dosage	Time administered