OKEECHOBEE CHRISTIAN ACADEMY

okeechobeechristianacademy.org

AUTHORIZATION TO ADMINISTER MEDICATION 2018-19

I hereby authorize OCA Personnel to administer the following medications to:

_____
(Student's Name)

Time	Medication	Dosage	RX#	Reason for Medication

_____ _____ _____
Physician Signature Printed Name Date

I understand that OCA has no clinic and will only dispense oral meds in the original container. I have read the parent/student handbook and agree with the policies on medical needs and illness.

_____ _____ _____
Parent/Guardian Signature Printed Name Date

[FOR OCA OFFICE USE ONLY]

Date	Time	Medication Given	Dosage	Initials

Date	Time	Medication Given	Dosage	Initials

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