



OKEECHOBEE CHRISTIAN ACADEMY

OkeechobeeChristianAcademy.org

AUTHORIZATION TO ADMINISTER MEDICATION 2019-2020

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

_____ (Student's First and Last 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