



OKEECHOBEE CHRISTIAN ACADEMY

OkeechobeeChristianAcademy.org

AUTHORIZATION TO DISPENSE MEDICATION 2020-2021

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

(Student's First and Last Name)

Time	Medication	Dosage	RX#	Reason for Medication

Physician Signature

Printed Name

Date

I have read the parent/student handbook and agree with the policies on "Dispensing Medicine to Students".

Parent/Guardian Signature

Printed Name

Date

[FOR OCA OFFICE USE ONLY]

Date	Time	Medication Given	Dosage	Initials

Date	Time	Medication Given	Dosage	Initials