

Great Bridge Christian Academy Medication Authorization Form

For Prescription and Non-prescription Medications



INSTRUCTIONS:

- **Section A** must be completed by the parent/guardian for **ALL** medication authorizations.
- **Section A and Section B** must be completed for any **long-term medication authorizations**, (those lasting longer than 10 working days).

Section A: To be completed by parent/guardian

Medication authorization for: _____ Date of Birth: _____
(Child's name)

Great Bridge Christian Academy has my permission to administer the following medication:

Medication name: _____ Dosage: _____

Frequency/Times to be administered: _____

AND/OR

Identify **specific** symptoms for as needed medication: _____

Special instructions (if any): _____

This authorization is effective from: _____ until: _____
(short term: 10 working days) (Start date) (End date)

Parent's or Guardian's Signature: _____ Date: _____

Section B: to be completed by child's physician for long term medication

I, _____ certify that it is medically necessary for the medication(s) listed
(Name of Physician)

below to be administered to: _____ for a duration that exceeds 10 work days.
(Child's name)

Medication(s): _____ Dosage: _____

Frequency/Times to be administered: _____

AND/OR

Identify specific symptoms for as needed medication: _____

Special instructions (if any): _____

This authorization is effective from: _____ until: _____
(Start date) (End date)

Physician's Signature: _____ Date: _____

Physicians Phone: _____

Great Bridge Children's Center

OFFICE USE ONLY: Reviewed Authorization Form Labeled Medication Recorded on Master Log Sheet

Staff member signature: _____ Date: _____

