K-12 Campus: 1615 Midwestern Pkwy,
Wichita Falls, TX 76302
Pre-K Campus: 4729 Neta Ln,
Wichita Falls, TX 76302
(940) 763-1347
www.wichitachristian.com

Prescription Medication Authorization Form

Student Name: _____ **Date of Birth**: _____

I, as the parent/legal guardian of the above-named student, do hereby request and grant permission for designated Wichita Christian School personnel to administer the medication(s) listed below as indicated on the prescription label and consult with the student's physician/licensed prescriber regarding any questions that may arise with regard to the listed medication(s) or medical condition(s) being treated by the medication(s).

On behalf of the above-named student, I also agree and do hereby waive and release all claims for loss, damage, or injury against Wichita Christian School and any personnel or other person arising directly or indirectly out of any act or omission relating to the receipt, administration, or execution of this request.

Parent/Guardian Signature: _____ Date: _____

Prescribed Medication

Medication Name: _____ Relevant Diagnosis: _____

Date Prescribed: _____ Prescriber's Name: _____

Dose: _____ Route: _____ Time/Frequency: _____

Relevant Side Effects: Yes No Specify: _____

Dates (M/D/Y) to Be Administered: from _____ to _____

Physican Signature: _____ Date: _____

Prescribed Medication

Medication Name: _____ Relevant Diagnosis: _____

Date Prescribed: _____ Prescriber's Name: _____

Dose: _____ Route: _____ Time/Frequency: _____

Relevant Side Effects: Yes No Specify: _____

Dates (M/D/Y) to Be Administered: from _____ to _____

Physican Signature: _____ Date: _____