

**Pullman Christian School**  
**Authorization for Administration of Medication at School**  
**2025-2026**

**This form must be completed by the student's parent/guardian.**

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

Name of Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Time of day to be taken: \_\_\_\_\_

For the treatment of: \_\_\_\_\_

Special instructions: \_\_\_\_\_

Possible side effects of medication:

\_\_\_\_\_

Emergency procedure in case of serious side effects:

\_\_\_\_\_

\_\_\_\_\_

**Parent Authorization**

I am the parent or legal guardian of the above-identified student and request/authorize the school to administer the medication listed below to my child in accordance with the above instructions/packaging directions for the period beginning (date) \_\_/\_\_/\_\_ through (date) \_\_/\_\_/\_\_ (not to exceed the current school year).

I understand that a dose may occasionally be missed despite every effort made by school staff to administer medication in accordance with the doctor's instructions.

Medication will be supplied to the school by me in the original container.

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**