TRINITY CLASSICAL ACADEMY

DISPENSING MEDICATION

Agreement to Assist Students with prescription and/or non-prescription medication

Pupils Last Name	First Name	Sex	Date of Birth	Grade

This section to be completed by a licensed physician

Purpose of Medication/Diagnosis	Name of Medication

Dose	Time	Frequency	Type (tablet, inhaler, etc.)

The Pupil for whom this medication is prescribed is under my care.

Printed Name of Licensed Physician	Signature of Licensed Physician

Address	Telephone Number	Date

This section to be completed by parent or guardian.

I, _____, the parent or legal guardian of _____

request that he/she be administered the medication described on this form by a nurse or other authorized employee of TCA. I understand that the medication will not be dispensed except as described in the physician's directions above. I hereby agree to hold TCA, its officers, agents, and employees harmless from any and all liability which may arise out of TCA's performance under this agreement.

Signature of Parent or Guardian	Date

Address

Home Number	Emergency Number

REQUIREMENTS:

1. All medication must be in the container originally supplied to the patient.
2. This agreement must be completed at the beginning of each school year as needed for ongoing prescriptions and for any changes in prescriptions during the school year.