COMMUNITY PREPARATORY ACADEMY

2017-18 COMMUNITY HANDBOOK

MEDICAL AUTHORIZATION/OTC FORM

_____/_____/_____

Student's Last Name, First Name DOB Grade

We understand that we must provide any over-the-counter (OTC) prescription or (RX) medications as prescribed by doctor:

- In its original container with proper labels; over-the-counter or prescription
- As an updated doctor's order if there is a change in dosage, schedule or health status
- Student may not carry OTC or RX medications
- Parent must pick up unused medications by last day of school, if not; the medications will be disposed of properly.

Allergies: _____

Severe Allergies: _____

Asthma Yes/ No (please circle)

Triggers of Asthma: _____

_____

I consent to CPA Staff communicating as needed with physician.
I consent to CPA Staff administering medication to my child.

_____/_____/_____/_____

Parent Name Parent Signature Date Phone Number

Section II. TO BE COMPLETED BY PHYSICIAN

Medication	Purpose/Diagnosis	Dosage	Time of School or Frequency	End Date

Special Instructions/Side Effects: _____ Physician Stamp Required

_____ May repeat rescue inhaler every 20 minutes (____), call parent, then 911 if needed.

Yes _____ No _____ I agree this student may carry inhaler, is capable and responsible.

_____/_____/_____

Parent Name Parent Signature Date

This request expires at the end of the school year in which it is made. New doctor orders are required each year.