

Beth Haven Christian School

5515 Johnstontown Road • Louisville, KY 40272

Phone (502) 937-3516 Fax (502) 937-3364

Dear Parent or Legal Guardian,

In Order for school personnel to administer any type of Medicine to your child the school must have a signed affidavit on file that gives your permission to distribute medication to your child. The medicine must be brought to the school office with completed information that is listed on the form below before returning it to the School Office. Unused medication must be picked up by the parents.

This authorization will be voided if not notarized. It will also expire at the end of the school year.

Sincerely,
School Office

I hereby request Beth Haven Christian School personnel to give medicine to my child, _____ . This medication has been prescribed by Dr. _____, whose office is located at _____ . The doctor's office phone number is _____

Date of last visit: _____

Starting date for medication: _____

Ending date for medication: _____

Reason for medication: _____

Possible side effects or reactions: _____

Instructions for Administering Medication

1. Name of Medication: _____
2. Dosage to be given: _____
3. Time for dosage to be administered: _____
4. Special instructions (e.g. not taken on empty stomach): _____

I give permission for the above information to be verified with my physician.

Parent's home phone: _____ Work Number: _____

Emergency Number: _____

NOTICE: SIGNING THIS FORM SHALL RELEASE BETH HAVEN CHRISTIAN SCHOOL AND ITS STAFF MEMBERS FROM ANY LIABILITY OF ANY NATURE THAT MIGHT RESULT FROM THE ADMINISTRATION OF MEDICATION TO THE STUDENT.

Signature of Parent or Legal Guardian: _____

Scribed and sworn to before me this _____ day of _____, 20____

Signature of Notary Public

My Commission Expires

