CALVARY CHRISTIAN ACADEMY

DRUG AND MEDICATION RECORD

Child: _____ Teacher: _____

Medication Name: _____ Storage: _____

Dosage: _____ Time(s) of administration: _____

Start Date: _____ End Date: _____

Side Effects / Special Instructions: _____

_____

Stop medication if the following reaction(s) is observed: _____

_____

I authorize Calvary Christian Academy staff to administer the above stated medication, using the instructions I have given the school, to my child.

Parents Signature: _____ Date: _____

DATE	TIME GIVEN	DOSAGE	STAFF INITIALS	COMMENTS / OBSERVATIONS