2023-2024 Medication Authorization Form

Merritt ACADEMY
Enjoy the Journey

This form authorizes Merritt Academy to administer medication to your child.

- **If medication will be administered for 10 working days or less, you do not need a physician's authorization.**
- Manufacturer's instructions for application must be followed unless authorized by child's physician.
- **If medication will be administered for 11 working days or more, you will need a physician's authorization.**

1 MEDICATION PER FORM

PART 1 PARENT OR GUARDIAN TO COMPLETE

I hereby request Merritt Academy (MA), personnel to administer medication as directed by this authorization. I agree to release, indemnify, and hold harmless Merritt Academy and any of their officers, staff members, or agents from lawsuits, claims, expenses, demands, or actions, etc., against them for helping this student use medication, provided Merritt Academy staff members comply with the physician, parent or guardian orders set forth in accordance with the provision of part I and II below.

Child's Name:	Date of Birth:	Classroom/Grade:
Diagnosis/Allergy/:		
Medication Name, (if **Name Brand** please list name below):	Medication Name, (if **Generic Brand** please list name below):	
Specify Dosage (e.g., mg, ml, or cc):	Time(s) or intervals:	
If medication is given on an as-needed basis, specify the symptoms or conditions when medication is to be taken and the time at which it may be given again.		
Any Adverse Reactions:		
Special Instructions (if any)		

Merritt Academy has my permission to administer the medication above.
(Note: If this authorization exceeds 10 working days, your child's physician must provide additional authorization)

_____ _____
(Parent's Signature) (Printed Name)

This medication is effective from: _____ and until _____ or ☐ August 14th, 2024
(first day administered)

Authorization may not exceed the last day of the 2023-34 program

PART II PHYSICIAN AUTHORIZATION (IF ADMINISTERED MORE THAN 10 DAYS)

I certify that, in my opinion, it is medically necessary that the medication and dosage described above be administered to the child listed above during the hours of operation at Merritt Academy.

_____ _____ _____
Physician's Signature Printed Name Date

FOR MERRITT ACADEMY OFFICE USE ONLY

Date Received: _____	Office Approval: _____	Medication Expiration Date: _____
Refill Date: _____	Office Approval: _____	Medication Expiration Date: _____
Refill Date: _____	Office Approval: _____	Medication Expiration Date: _____