MEDICAL AUTHORIZATION FORM

I herewith acknowledge that I am primarily responsible for administering medication to my child. However, knowing that I am unable to do so during the school day or in the event of a medical emergency, I hereby authorize Grandville Calvin Christian School and its employees and agents to administer to my child (or allow my child to self-administer, while under the supervision of the employees and agents of Grandville Calvin Christian School) lawfully prescribed medication. I acknowledge and agree that when the lawfully prescribed medication is so administered I waive any claims that I might have against the Grandville Calvin Christian School, its employees and agents arising out of the administration of prescribed medication and agree to hold harmless and indemnify the Grandville Calvin Christian School and it's employees from and against, any and all claims, damages, causes of action or injuries incurred ore resulting from the administration of prescribed medication.

STUDENT_____

Teacher_____

Parents_____

Address_____

Phone: Home_____ Work_____

NAME OF MEDICATION _____

Number of milligrams per dose_____

Time(s) of the day (i.e. 9 am)____ ____ ____ ____

Will this medication be self-administered or self-carried? Yes No

Comments_____

Physician's name_____

Parent's signature_____Date_____