Trinity Christian Academy

Over-the-Counter Medication Authorization and Medication Log

Name: _____ Grade: _____ Date of Birth: _____

Name of Medication: _____

Frequency/Time of Dose: _____ Date to Begin:_____ Date End: _____

Physician Name: _____ Phone:_____

Parent's Name:_____ Phone:_____

I hereby authorize Trinity Christian Academy to disense the above medication(s) as indicated on this form for the dates and times above. Medication must be in the original packaging and labeled.

Parent's Signature: _____ Date: _____

OFFICE USE:

Date	Time	Dosage	Initialed By	Date	Time	Dosage	Initialed By

Medication was picked up on _____ (Date) by parent. Signature _____