mount pisgah
CHRISTIAN SCHOOL

Mount Pisgah Christian School Summer Camp 2020
Authorization - PRESCRIPTION Medication/Treatment

Student's Name: _________________________________ Rising Grade: _________
Camp Weeks: ____
Primary Parent Name:_____________________ Cell # for Texts:_______________

I hereby request that Mount Pisgah Christian School, through its designated authority, supervise/assist in the administering of medication to my child, ____________________________, according to the instructions contained on the physician's statement. I release the school, and any school employee, from any liability for administering this medication.

Parent/Guardian Signature ___________________________________Date _______________

PHYSICIAN'S STATEMENT NAME OF MEDICATION __________________________
DOSAGE ____________ Time medication is to be given during the day: _______________

Expected duration of administration of medicine: ___________________
Possible side effects, if any: ___________________________________
Suggested basic first aid procedures for handling possible side effects:
____

Is this student in need of assistance in administering this medicine? YES NO
If YES, explain assistance needed: ____

Physician's Name, Address and Phone Number. Please Print:
____
____

Thank you! Please email a photo or scan of this form to: MPAA@mountpisgahschool.org