Student Medical Authorization Form 2025-2026

Student's Name_____ Date_____

Teacher's Name_____ Grade_____

Medication Name _____ Dose_____

Route to be Administered (circle one): By Mouth Inhalation Topical Injection

Date and Time to be Administered _____

This medication is needed for_____

If the medication is to be given as needed, please describe the symptoms: _____

_____

Discontinuation Date (if applicable) _____

It is helpful if medication is administered at home rather than school whenever possible. If medication from home must be administered at school, parents are required to sign this medical authorization form and send the medication in its original, pharmacy-labeled container. **All medication must be checked in with front office personnel upon arrival at school. Students may not keep medication with them while at school.**

I understand that my child will be assisted in taking the medication(s) described above at school by an authorized person(s). The undersigned agrees to release, indemnify, and hold harmless Cambridge Academy, its employees, or representatives from any claim, liability, or expense arising out of or in any way connected with the giving or failure to give prescribed medication to my child. This release and indemnity agreement includes claims based on alleged negligence on the part of Cambridge Academy or its employees. In addition, I agree that it is my responsibility to inform the school, in writing, of any change in medication and/or its distribution to my child.

Parent's Name_____ Signature_____

Address_____ City_____ Zip Code _____

Home Phone_____ Work Phone_____

Emergency Contact and Phone Number _____