

**Solid Foundation Foundation Preparatory Arts Academy
Medication Information & Authorization Form**

Student's Name _____ DOB _____

Known allergies: _____

Medication: _____

Route of Administration: _____ Dosage: _____

Frequency: _____ Time(s) of Administration _____

Name of Licensed Prescriber: _____ Title: _____

Business Phone Number _____ Emergency Phone Number _____

I authorize the designee to give the above named medication to my child.

Student's Name _____ Grade _____

Signature of parent/guardian _____ Date _____

EMERGENCY CONTACT _____ PHONE # _____

List of other medications _____

I give SFPAA permission to administer the following medications without prior consent: (check all that apply)

Acetaminophen Benadryl Neosporin Anti-itch cream

I understand that I may retrieve the medicine from the school at any time and that the medicine will be destroyed if it is not picked up within one week following the last day of school.

Parent/Guardian Signature _____ Date _____

Forms can be submitted electronically to tpayne@sfpaeagles.com