HIGHPOINT ACADEMY

Coral Way Campus

2026-2027 MEDICATION AUTHORIZATION FORM

This form is valid only for the **2026-2027** school year including the summer session. This form must be completed fully for Highpoint Academy to administer the required medication during school hours. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of a medication.

- Prescription medication must be in a container labeled by the pharmacist or prescriber.
- Non-prescription medication must be in the original container with the label intact.
- An adult must bring the medication to the school.

TO BE COMPLETED BY PRESCRIBING PHYSICIAN

Patient Name	DOB	Medication Name	Dose
Condition for which medication is being administered		**Time/frequency of administration**	
Possible side effects and significant information			
Does medication need refrigeration?			**YES** **NO**
Does medication need to be sent home with child each afternoon?			**YES** **NO**
Physican Name (Printed)			
Physician Signature			
ADDRESS	**PHONE NUMBER**		**DATE**

PARENT/GUARDIAN AUTHORIZATION

I/We request designated Highpoint Academy school personnel to administer the medication as prescribed by the above named physician. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at Highpoint Academy. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded.

Parent/Guardian Name (Printed): _____

Parent/Guardian Signature: _____ Date: _____