



I hereby give permission to Foundations Academies to administer the following medication to my child according to the specific directions as stated below:

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Beginning Date of Administration: \_\_\_\_/\_\_\_\_/\_\_\_\_

**EXPIRES ON: \_\_\_\_/\_\_\_\_/\_\_\_\_**

Ending Date of Administration: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Medication: \_\_\_\_\_

Method of Administration: (circle one) Oral Topical Injection Other: \_\_\_\_\_

Amount to be Administered: \_\_\_\_\_ Times to be Administered: \_\_\_\_\_

What symptoms would need to occur for medication to be administered? (Must be completed)  
\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date Received: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date Released: \_\_\_\_\_

**FOR THE SAFETY OF THE CHILD, ALL MEDICATION MUST BE SUBMITTED TO THE FRONT OFFICE AND MUST BE ACCOMPANIED WITH A MEDICATION AUTHORIZATION FORM. MEDICATION SHOULD NEVER BE PLACED IN CHILD'S BACKPACK OR LUNCHBOX, AND MUST NOT BE GIVEN DIRECTLY TO TEACHER. NEW EMERGENCY TREATMENT FORM MUST BE SUBMITTED WITH ANY NEW ALLERGY OR HEALTH CONDITION.**

**Medication Administration Log**

| DATE | TIME | AMOUNT | INITIALS | DATE | TIME | AMOUNT | INITIALS |
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Foundations Academies is nationally accredited through the Southern Association of Colleges and Schools and State Accredited through the Florida League of Christian Schools (#15348). Foundations Academies is additionally licensed through Sarasota County (#58-51-01953). Foundations Academies is recognized by the Department of Education as a private, non-public school (#5780).

**OFFICE USE ONLY:** Date Received \_\_\_\_/\_\_\_\_/\_\_\_\_ By \_\_\_\_\_  
Date Released \_\_\_\_/\_\_\_\_/\_\_\_\_ By \_\_\_\_\_