2023-2024 PROVIDENCE CHRISTIAN ACADEMY

PARENTAL REQUEST FOR ADMINISTERING **PRESCRIPTION** MEDICATION AT SCHOOL

Student Name: _____ Grade: _____

_____Please check here if your child DOES NOT take any prescription medication that must be administered at school.

This order is valid only for school year (current) _____including any summer session.

- **This form must be completed fully in order for schools to administer the required medication.**
- **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 with the original label completed by the pharmacy or prescriber, unless other approved delivery method.

*An adult must bring the medication to the school.

Student Name: _____ (Please Print)

Date of Birth: _____

Grade/Teacher: _____

Allergies: _____

Name of Medicine: _____ (Please Print)

Date Prescription Filled: _____

Dose/Amount to be given: _____ (Please Print)

Route (orally, etc): _____

Time/frequency of administration: _____

If PRN, frequency: _____

If PRN, for what symptoms: _____
(Please Print)

Medication shall be administered from: _____ to _____
Month/day/year Month/day/year

Prescriber's Name/Title: _____

Condition for which medication is being administered: _____

I/We request designated school personnel to administer the medication as prescribed by the above-named prescriber. I/We certify that I/We have the legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication within 2 weeks, otherwise it will be discarded.

Parent/Guardian Signature:_____Date:_____

Phone Number: _____