PROVIDENCE
CHRISTIAN ACADEMY

PARENTAL REQUEST FOR ADMINISTERING PRESCRIPTION MEDICATION AT SCHOOL

*If your child DOES NOTtake anyprescription medication that must be administered during school, this form does NOT need to be completed.

Academic Year _____

Student Name: _____ Grade: _____

- ☐ This form must be completed fully for PCA to administer the requested 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.

  Initial _____

*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.

Allergies:_____

Name of Medicine: _____ (Please Print)

Date Prescription Filled: _____ Dose/Amount to be given: _____

Route (oral, injection, topical, etc.): _____ Time/frequency of administration: _____ If "as needed", frequency: _____ If "as needed", for what symptoms: _____ Medication shall be administered from: _____/_____/_____ until _____/_____/_____

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. This order is valid only for the current school year.

Parent/Guardian Signature: _____Date: _____

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