hope lutheran
CHRISTIAN SCHOOL

REQUEST FOR ADMINISTRATION OF MEDICATION

Note: No Medication will be given until this form is completed and returned to the school.

Student's Name: ____ Birth date: _____________________

Student's Address: ____

Parent / Legal Guardian: ____

Phone: (home) _______________________ (work) ______________________________

Other people to contact in emergency:

1. ____ Phone: _______________________

2. ____ Phone: _______________________

Family Physician: ________________________________ Phone: _______________________

Prescribing Physician: ____________________________ Phone: _______________________

Medical Condition: ____

Medication Required: ____

I request that staff give medication as prescribed on this form to my child.

❖ If non-prescription medications are to be given, a note from the doctor will be provided.
❖ I agree to supply the medication to the school in the original container with the child's name, prescribing physician's and pharmacist's direction for use including dosage.
❖ Consequences of missing medication dose or increased dosage given (as identified by prescribing physician), side effects (as identified by parent/guardian and student) are included.
❖ If changes occur I will contact the school and provide revised instructions. I am aware I am required to update this information each September.
❖ I am aware that the Public Health Nurse for the school will be informed of my child's condition and medication and that the nurse may contact me as necessary.
❖ I am aware that staff and other personnel working with my child will need to know of my child's condition and of the medication required.

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Signature of Parent / Guardian Date