NORTHWEST CHRISTIAN SCHOOL

Parent/Guardian Request for Administration of Medication by School Personnel

CONFIDENTIAL

Part A: Must be completed for the *NCS Health Office* to administer any mediation to a student.

Student Name:_____DOB:_____

Teacher/Grade:_____Known Drug Allergies:_____

As the parent/guardian of the above named child, I give permission for him/her to be given the medication as described below by the nurse(s) in the health office or whomever the health office or administration designates in the absence of a nurse. I hereby give the school RN permission to contact the prescriber if there are questions or concerns about the prescription.

Name of Medication:_____Medication Strength:_____

Route of Administration (please circle): by mouth, inhaled, topical, eye(s), ear(s), nasal, injection (IM SQ IV) OR rectal

Dosage:_____Reason for Taking:_____

Give Daily—Time(s):_____ ****OR**** Give PRN/As Needed—Frequency:_____

Medication Start Date:_____Medication End Date:_____Medication Exp Date:_____

Special Instructions:_____

Other Medication(s) Student is Taking:_____

Original Date Received:_____Amount/Number:_____Staff Signature:_____

CHANGES**Date:_____Change in Dose, Amt or Time:_____Parent Initials:_____

REFILLS**Date Received:_____Amount/Number:_____Staff Signature:_____

#1_____

#2_____

#3_____

#4_____

I acknowledge that NCS will not administer more than TEN doses of the same type of "over the counter" medication unless the request is accompanied by PART B (Health Care Provider Order---see reverse side). I must supply a NEW bottle of medication in its original container and unexpired. If a medication or dosage is changed, I will notify the health office immediately. NCS will confiscate and take disciplinary action if the student misuses medication, including un-authorized possession or self-administration. Medication not picked up by the end of the school year will be properly disposed of.

Printed Name of Parent/Guardian:_____Daytime Phone Number(s):_____

Signature:_____Relationship to Student (i.e. Mom, Dad, Grandma):_____

Today's Date:_____

Med Pick-Up Date:_____By:_____Relationship:_____Staff Initials:_____

Revised 5/2019

Part B: Must be completed by a health care provider (MD, DO, PA, NP or Homeopath) for NCS to administer medication to a student taking more than TEN doses of the same medication in a school year.

I request the following student be given medication at school because I believe there exists a valid health reason which necessitates medication administration during the school day "AS NEEDED".

Student Name:_____DOB:_____

Medication:_____Time to be administered at school:_____

Condition being treated:_____Dosage & Mode of Administration:_____

Side effects to be expected, if any:_____

Other medications the school should be aware of:_____

Health Care Provider Name (Printed):_____

Health Care Provider Signature (MD, DO, PA, NP or Homeopath):_____

Health Care Provider Address:_____

Date:_____Telephone:_____Fax:_____Email:_____