**Christian Academy Schools**
2151 W. Russell Rd. Sidney, Ohio 45365
Phone: 937-492-7556 Fax: 937-492-5399

*Our Mission is to Equip and Inspire Students to be a New Generation of Christ-Centered Leaders*

## Physician's Request for the Administration of Medication by School Personnel

Student's Name_____ Date of Birth_____

Physician's Name_____ Phone_____

**Physician – Please Complete:**

Name of Prescription_____ Dose_____ Time(s)_____

Reason for prescription to be administered at school_____

_____

Beginning date of request_____ Expiration date of request_____

Special instructions for administration_____

Side effects to watch for_____

Physician's Name_____ Date_____

**Parent Must Indicate that the Student is Allowed to Self-Carry their Emergency Medication & Supplies**

◊ I authorize and recommend self-medication by my child for the prescribed listed medication.
Medication_____

◊ I also affirm that my child has been instructed in the proper self-administration of the prescribed medication by their attending prescriber.

**Parent/Guardian-Please Complete:**
**Parents' Permission for the Administration of Medication by School Personnel**

I hereby request and give my permission to the Head of School or a designee (nurse, secretary, teacher, or other responsible person) to administer the above-named medication to my child by the above names physician as it is prescribed:

Parents Signature_____ Phone_____ Date_____

**Parents MUST send medication to school in its original container.**

Note: The parent/guardian of the child must assume responsibility for informing the Head of School and school nurse of any change in the child's health or any change in the prescribed medication. Any change to the above prescription (dosage or administration) will require the completion of a new form.

School Official's Signature (Acknowledging Receipt)_____

Date_____