REQUEST FOR MEDICATION TO BE GIVEN DURING SCHOOL HOURS

This request must be signed by parent/guardian to authorize medication during school hours.

Southview Christian School

Student's Name: _____ Grade: _____ Diagnosis: _____

Medication: _____ Dosage: _____ Route: _____

Time to be given: _____ Purpose of medication: _____

Significant information: (include side effects and toxic reaction)

_____

_____

Duration of order from _____ to _____

Prescribing Physician's Name: _____ Physician's Phone: _____

Physician and Parent please note: NO controlled substance (with the potential to impair student's ability to function at school, ie: stay awake in class, potential for falling) shall be maintained or given by the school unless imperative to have for the student's education or for life threatening situation.

TO BE COMPLETED BY PARENT OR GUARDIAN:

I request that my child be administered the medication as indicated in the physician's order above. I understand that non-medical personnel may conduct the administration or injection of medication. I understand that it is my responsibility to furnish this medication within a container properly labeled by a pharmacist with identifying information, e.g., name of child, medication dispensed, dosage prescribed, and the time it is to be given and to transport the medication to school unless special arrangements are made. I authorize the release and exchange of medical and educational information between my child's physician and school staff that is necessary in carrying out this service to my child.

_____ _____ _____

Parent/Guardian Signature Telephone/Cell Date