CHRISTIAN HIGH SCHOOL

2018–19 STUDENT MEDICATION RELEASE FORM

NOTE: THIS FORM MUST BE SIGNED BY PHYSICIAN OR NURSE PRACTITIONER **AND** A PARENT/GUARDIAN
Medication must be in the prescribed bottle or original package.

Please print:

Student Name _____ Date of Birth_____

Home Address_____City, State, Zip_____

PHYSICIAN'S ORDER FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL:
Check one:
___ I have prescribed the following medication for this child and request school personnel administer the dosage given during school hours.
___ It is my professional opinion that this student is capable of carrying & self-administering the following medication:

Medication _____

Dosage and time of administration _____

Purpose or condition for which prescribed
_____

Check one:
___ Daily
___ As needed (PRN)

Signature of Health Care Provider: _____ Date _____

Office Address _____ Phone _____

PARENTAL RELEASE FOR ADMINISTRATION OF MEDICATION:
Check one:
___ I request that the above medication be given to my child as prescribed by the physician. I understand I must provide this medication in the original bottle, properly labeled by the pharmacy with student's name, date, dosage, time and directions for administration. I release school personnel from any liability in relation to the administration of this medication at school.
___ I request and authorize my child to carry and/or self-administer their medication.

Parent/Guardian signature: _____ Date_____