NORTHWEST CHRISTIAN SCHOOL

Parent Request for Administration of Medication by School Personnel

CONFIDENTIAL

PART A: Must be completed for NCS Health Office to administer any medication 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: ☐ by mouth ☐ inhaled ☐ topical ☐ eye(s) ☐ ear(s) ☐ nasal ☐ injection (circle: IM SQ IV) ☐ rectal			
Dosage	Reason for Taking		
Give Daily Time(s):	OR	Give PRN/As Needed Frequency:	
Medication Start Date	Medication End Date	Medication Expiration Date	
Special Instructions			
Other Medication(s) Student is Taking			

CHANGES	Date	Change in Dose, Amount, or Time	Parent Signature
	Date	Change in Dose, Amount, or Time	Parent Signature

MEDICATION CHECK-IN			
Date Received	Amount/Number	Clinic Staff Signature	Parent/Guardian Signature
Original			
REFILL(S)			
#1			
#2			
#3			
#4			
#5			
#6			
#7			
#8			

I acknowledge: 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 destroyed.

Printed Name of Parent/Guardian____

Signature_______________________Relationship to Student (i.e. Mom, Dad)__________

Daytime Phone Number(s)________________________Today's Date______________

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________________

Med Pick-Up Date_________By____________________Relationship__________Staff Initials____

Revised 1/2019