Christ the King School
CHARACTER KNOWLEDGE SPIRIT

MEDICATION ADMINISTRATION FORM

Student's Name: _____ Birth Date: ____/_____/_____
Grade: _____Teacher:_____
List any drug allergies/reactions:

PARENT OR LEGAL GUARDIAN AUTHORIZATION (for *ALL* medications)

If a medication must be given during school hours, this form must be completed by a parent/guardian in order for school personnel to administer any type of medication to your child. The parent/guardian must provide the school with the over-the-counter or prescription medication in the original pharmacy-labeled container with an unexpired date. The medication will be given as directed on the package or per concise directions (name of medicine, dosage, and frequency) by the prescribing physician. It is the responsibility of the parent/guardian to notify the school of medication changes and complete a new Medication Administration Form. A parent/guardian must pick up unused medication within two weeks of the ending date or it shall be destroyed. This authorization expires as of the last day of the school year.

Name of medication: _____ ☐ Daily or ☐ As needed
Dosage: _____Frequency/Times to be given: _____ Medication expiration date: _____
Medication for: ☐ This school year 20____-20____ ☐ Following dates only: _____

Physician's Name: _____ Phone number: _____

Pharmacy Name: _____ Phone number: _____ Hospital of choice: _____

I hereby request school personnel to give medication to my child.

Signature of Parent/Legal Guardian: _____ Date: _____

Parent/Guardian's Home phone #:_____ Work phone #:_____ Cell phone #:_____

PHYSICIAN AUTHORIZATION (for <u>prescription</u> medications *ONLY*)

Please follow these instructions:

1. Name of medication:_____
2. Dosage:_____ Route: _____Frequency/Time to be given:_____
3. Start medication on: _____/_____/_____ Stop medication on: _____/_____/_____

Condition/Illness requiring medication: _____
Common side effects of the medication: _____
Student may carry and self-administer medication due to a life threatening condition: ☐Yes ☐No
Special instructions: _____

Physician's Signature: _____ Date: _____

Physician's Name: _____Phone number: _____

Please return completed form to the school Clinic or send via fax # 859-266-4547.