

**Request for Administration of Medication**  
(Prescription and non-prescription)  
2019-2020



Name of Student: \_\_\_\_\_  
Last Name First Name M.I.

Student's Grade \_\_\_\_\_ Student's Birth Date: \_\_\_\_\_

If a student must receive prescription or non-prescription medication at school, a written request completed by both the licensed prescriber (for prescription medication) and the parent or guardian must be on file at the school. The medication will be administered by the administrative assistant, office assistant, or designated personnel.

All prescription medication must be in the original container labeled by the pharmacist or licensed prescriber. This includes eye drops, ear drops, ointments, and inhalers. The label must include the name of the student, the name of the medication, the dosage, the time to be taken, the prescriber's name, and the date.

Provided that the requirements of this form are fulfilled, a student with asthma or another airway constricting disease may possess and use his/her medication while at school or school-sponsored activities. If the student misuses this privilege, the privilege may be withdrawn.

Non-prescription medication must be in the original labeled container with the student's name affixed to the container.

Unless ordered for a short term, all requests for administration of medication will expire at the end of the school year. If the parent/guardian does not pick up any unused medication, the office staff will dispose of the medication.

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When it is necessary for a student to receive medication at school according to the procedure enclosed, the following information must be provided:

Name of medication: \_\_\_\_\_

Dosage: \_\_\_\_\_ Time to be administered at school: \_\_\_\_\_

Start date: \_\_\_\_\_ Stop date: \_\_\_\_\_

Medication side effects: \_\_\_\_\_

Prescriber's name (prescription only): \_\_\_\_\_

Prescriber's signature (prescription only) \_\_\_\_\_

Telephone: \_\_\_\_\_ Date: \_\_\_\_\_

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**TO THE PARENT/GUARDIAN:**

I give permission for \_\_\_\_\_ to receive medication as prescribed above. I agree to the terms of the procedure as stated. It is understood that in instances where the student self-administers medication, Tri-State Christian School shall not in any way be responsible that said student administers the proper medication or dosage. Parents and/or legal guardians agree to save and hold harmless, completely release and excuse Tri-State Christian School and its employees of any liability or obligation of any nature in any way related to the Medication Policy and Procedure.

Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_