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# Request for Medication Administration

## Student Information

Student's Name \_\_\_\_\_  
*Last* *First* *Middle*

Home Phone \_\_\_\_\_ Gender  Male  Female Grade \_\_\_\_\_

Home Address \_\_\_\_\_

Father's Name \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_ Daytime Phone \_\_\_\_\_

## Emergency Contact Information

Contact Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to Child \_\_\_\_\_

## Medication Information

Medication to be administered \_\_\_\_\_

Dosage to be administered (*please include times or intervals*) \_\_\_\_\_

Begin Date \_\_\_\_\_ End Date \_\_\_\_\_

## Physician Information

Student's Physician \_\_\_\_\_ Physician's Phone \_\_\_\_\_

Physician's Address \_\_\_\_\_

I request that Shrewsbury Christian Academy administer the above medication to my child in accordance with my request and the physician's statement of need. I agree to notify the school in writing of any changes in my child's condition with respect to the administration of medication or with any changes to the information provided on this form. I understand that it is my responsibility to send an appropriate supply of medication to the school in its original container with the prescription label from the pharmacy attached. Medication provided to the school in any container other than the original container will not be accepted. I understand that the school will have limited liability while administering medication to my child in accordance with a physician's statement of need. The school agrees to keep a written log of medication administered to my child in school throughout the current school year.

Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_