

GRANVILLE CHRISTIAN ACADEMY
Request for Administration of Prescription Medication

Some students may need prescription medicines throughout the school year. If possible, all medication should be given under the supervision of parent/guardian outside of school hours. When this is not possible, school personnel may give prescribed medication when complete documentation of all information, as requested from physician and parent/guardian, is received and the medication is delivered to the school by the parent/guardian in the original labeled container in which it was dispensed by the physician or pharmacist. The container needs to have a pharmacist's label with the following information: student name, physician name, date, pharmacy name and telephone, name of medication, prescribed dosage and frequency, and special handling and storage directions.

Student Name _____ **School Year/Grade** _____

Address _____ **Parent's Daytime Phone/Cell Phone** _____

Allergies

Information from Prescribing Provider: The following medication needs to be administered during school hours and is being prescribed for that time. I understand that unlicensed school personnel may be assisting the child with the administration of this medication.

Name of Drug	Amount to be given	Time To be given	Route of Administration	Indications for Medication	Adverse Reactions To report

If allowed to carry inhaler, document training and conditions:	
For asthma, provide peak flow meter and acceptable range:	
Date to Begin:	
Date to End: (Valid for current school year only)	

Print Physician Name, Address & Telephone

Physician Signature

Parent/Guardian Information

I request that the prescribed medications listed above by the physician be administered to the student. I agree to submit in writing a revised physician's statement in the event that any of the required information should change during the school year. I give permission for the principal or school nurse to contact the physician regarding the administration of these medications in the school setting. I agree to deliver the needed medication to the school in the proper container. I agree to pick up medication within 3 days of termination of administration or end of school year, or school staff will dispose of medication.

Parent/Guardian Name

Signature

Date

For School Use Only

Request Accepted _____ Request Denied (reason below) _____ School Nurse Initials _____ Principal Initials _____