COLUMBUS CLASSICAL ACADEMY

Request form for the administration of ***Prescription*** *medication at school*

(One medication per form)

I hereby request and give my permission to the Head of School or his designee (school nurse or other responsible person) to administer the following medication(s) to my child.

To be filled out by the prescriber.

Student: _____ Year: _____ Grade: _____

Medication: _____ Dosage: _____

Reason for administration/ diagnosis: _____

_____

Contraindications for administration: _____

_____

_____

Potential adverse reactions or side effects: _____

_____

Does the medication require refrigeration? Yes_____ No _____

Is the medication a controlled substance? Yes_____ No _____

Dates to be given: _____ to _____

Time(s) of the Day: _____am/pm

_____am/pm

_____am/pm

_____ As needed

Prescribing physician printed name_____

Prescribing physician signature _____ Date:_____

Prescribing physician contact information: _____

_____ Phone number: _____

Parent/Guardian signature: _____ Date: _____