Request for Medication Administration

(To be completed by parent of guardian)

DO NOT RETURN FORM WITHOUT <u>SUPPLYING MEDICATION</u>

Student Name ______________________________ Birthdate ______________________

Address ______________________________ Phone ______________________

School ______________________________ Grade ______________________

Parent Name(s) ______________________________ Daytime Phone ______________________

______________________________ Daytime Phone ______________________

Emergency contact ______________________ Phone ______________________

Please understand that Vineyard Christian Middle School *can not* dispense any medication including over the counter (cough drops, Advil, Motrin, Tylenol, Pamprin, Midol) or prescription medication without *parent permission and medication supplied to the school* (please see below).

Medication to be administered ______________________________

Dosage to be administered ______________________________

Time or interval at which each dosage is to be administered ______________________

I, ______________________ request that Vineyard Christian Middle School administer the above medication to my child in accordance with my request and the physician's statement of need (necessary for prescription medication). 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 the form. **I understand that is it my responsibility to send an appropriate supply of medication to school in its original container, in a zip-lock bag with my child's name on it. Medication provided to the school in any container other than the original 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 Signature ______________________________ Date ______________________

Physician Statement of Need

Student's Name________________________________Birthdate____________________

Student's Address____

School____Grade_________

Medication to be administered____

Does this medication have a generic name also?_________________________________

Dosage to be administered____

Time or interval at which each dosage is to be administered________________________

Date to begin administration____

Date to cease administration____

Possible adverse reactions____

____

List of severe reactions that should be reported to the physician_____________________

____

Special instructions for storage of medication___________________________________

____

Physician's name_____________________________________

Physician's address___________________________________

Physician's phone number_____________________________

Emergency contact information for physician____________________________________

Physician's Signature___________________________________Date________________