JOHN KNOX CHRISTIAN SCHOOL

ADMINISTRATION OF MEDICATION

TO BE COMPLETED BY THE PARENT/GUARDIAN:

I/we _____ (please print name) request the administration of medication during school hours to_____ (name of child).

Description of medication:

Name of medication	Amount/dose at each time	Time of dose	Beginning –Y/M/D	Ending –Y/M/D

Reason for medication:

_____

_____

I/we are responsible for the delivery of the medication in the original container along with the instruction to the school.

I/we release JKCS and its employees from any liability for loss, damage or injury however caused to my child's person or property arising out of administering or failure to administer the medication described above.

DATE _____

HOME PHONE _____

BUSINESS PHONE _____

CELL PHONE _____

PARENT/GUARDIAN SIGNATURE _____