Calvary Day School Prescription Medication Form

Student Name _____

Birth Date_____ Grade _____

This form shall be completed for all prescription medication that is to be administered by the school nurse or designee. The medication is to be hand-carried to the Health Room (E1102) by the parent/guardian and must be in its original pharmacy-labeled container. A separate form is required for each medication. Please refer to the Calvary Day School medication policy found in the student handbook for further information.

PHYSICIAN STATEMENT OF NEED (This box to be completed by the physician)

Name of Medication_____
Strength _____ Dosage _____mL _____Tablet(s) _____

(Other) Time(s) to be taken at school: _____ To be given from_____to_____ Reason for

Medication_____
Side effects (expected /predictable):_____

Prescribing Physician's Name (Print):
_____

Office Phone_____

PHYSICIAN SIGNATURE_____ **Date**_____

PARENT'S PERMISSION

● I hereby give permission for my child (named above) to receive medication during school hours 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 regards to the administration of this medication or with any changes to the information provided on this form.
● I hereby authorize the school nurse to share this information with Calvary Day School staff as necessary for the safety and welfare of my child during the school year.
● I do hereby release Calvary Day School from any liability that may result from the prescribed medication.

_____ _____

PARENT/GUARDIAN SIGNATURE **DATE**