

MASON COUNTY CHRISTIAN SCHOOL
Physician's Orders for Medication at School

Student: _____ Date: _____

Medication is ordered to be given to a student at school only when absolutely necessary. Whenever possible, the parent and physician are urged to design a schedule for giving medication outside of school hours. If this is not possible, the parent must understand that the principal or his/her designee will dispense the medication. The principal will designate the person responsible to dispense medication on an individual basis.

The school accepts no responsibility for untoward reactions when the medication is dispensed in accordance with the physician's directions.

Is it necessary to dispense this medication during school hours? [] yes [] no

If yes, please give diagnosis or reason: _____

Drug(s) and dosage form: _____

Dose and mode of administration: _____ Hour(s) to be given: _____

If given PRN (as needed) specify the length of time between doses: _____

Side effects of drug (if any) to be expected: _____

Inhaler to be carried by student: [] yes [] no

Physician Signature: _____ Print or stamp name here: _____

Date: _____ Phone Number: _____

Parent's Permission for Medication at School

[] I request that the principal or a staff member designated by him/her be permitted to dispense to my child, (name of child) _____ the medication prescribed by (name of physician) _____ for a period from _____ to _____.

[] I request that the principal or a staff member designated by him/her be permitted to dispense to my child, (name of child) _____ the following over-the-counter medication, _____, at {specific time(s)/dose(s)} _____ for a period of time from _____ to _____.

The medication is to be furnished by me in the original container, labeled by the pharmacy or physician or manufacturer with the name of the medication, the amount to be taken, and the time of day to be taken. The physician's name is to be on the label for all prescription medications.

I understand that my signature indicates my understanding that the school accepts no liability for untoward reactions when the medication is administered in accordance with these directions. **This authorization is good for the current school year only.**

In case of necessity, the school may discontinue administration of the medication with proper advance notice. If notified by school personnel that medication remains after the course of treatment, **I will collect the medication from the school or understand that it will be destroyed.** I am the parent or the legal guardian of the child above-named.

Date: _____ Signature of Parent/Guardian: _____