FIRST BAPTIST
christian schools

Request for Medication Administration
PRESCRIPTION

(To be completed by parent or legal guardian)

Student Information (please fill out one form per student):

Name _____ Birth Date _____

Grade _____ Teacher _____ Rm # _____

Emergency contact information:

Parent/Legal Guardian Name _____ Relationship _____

Physical Address _____

Home Phone _____ Cell Phone _____

Work Phone _____

Medication Information (please fill out one form per medication):

Medication Name _____ Prescription # _____

Dosage Instructions _____

Begin Medication Administration _____ Terminate Medication Administration _____

Medication Expiration _____

Administering Physician _____ Phone _____

Physician Address _____

I request that the school administer the above medication to my child in accordance with my request or the physician's statement of need. 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 this original form. I understand that it is my responsibility to send an appropriate supply of medication to school in its original container. 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.

X _____ _____
Signature of Parent or Legal Guardian Date

For Office Use Only:

School Year: _____

Medication Stored: □ In Office □ In Classroom # _____ Lockbox # _____

Expired Medication Notification: □ 1st Notification Date: _____ Initials: _____ □ Phone □ Email □ In Person

□ 2nd Notification Date: _____ Initials: _____ □ Phone □ Email □ In Person

□ Medication stored in Expired Meds Box: Date _____ Initials: _____