Fairfield Christian School
Medication Administration Form
2026-2027

Date:_____/_____/_____ Student:_____ Age:_____

Parents:_____ Teacher:_____

Address:_____ Doctor:_____

Phone: (_____)_____ Dr.'s Phone: (_____)_____

Please be advised that we have authorization from the above-named doctor for our student to receive prescription medication. The following instructions should be followed when administering this prescription:

Medication Name:_____

Reason for Administering:_____

Duration of Prescription:_____

☐ This is a non over-the-counter prescription and should be kept in a secure location.

☐ My child needs to have this prescription administered at the following:

Times:_____ Dosage:_____

☐ Other Important Information:

_____

_____

_____

Parent or Guardian Signature _____

(two-sided document revised

Medication Record

DATE	TIME(S)	NAME OF MEDICATION	STRENGTH OF MEDICATION	DOSAGE/STAFF INITIAL