ROSEHILL CHRISTIAN SCHOOL

2023-2024

REQUEST TO DISPENSE PRESCRIPTION MEDICATION

To Be Completed by the Physician:

Since medication for the student listed below cannot be scheduled for other than school hours and the administration of such medication may be supervised by non-medical personnel, it is requested that the medication as indicated below be administered by Administration or its designee.

1. Name of Student: ____ Date of Request: ____________________

2. Address of Student: ____ Zip Code: ___________________________

3. Medication(s) to be administered (per prescription label):

a. ________________________________ Purpose: ____

b. ________________________________ Purpose: ____

c. ________________________________ Purpose: ____

4. Possible reaction that, if they occur, should be reported to the physician:

a. ____

b. ____

5. Any special instructions (e.g. storage): ____

6. Medication to be continued as above until: **Begin Date:** _____________ **Discontinued Date:**_________________

7. Physician's Signature: ____

Address: ____

Phone Number: __________________________ Emergency Number: ____________________________________

To Be Completed by the Parent / Guardian:

I (we) request that medication be administered to our child: in accordance with the above instructions of our physician, Dr. ________________________________

I (we) understand that the administration of said medication is to be dispensed under the supervision of either a member of Administration or their designee.

I (we) understand that the medication is to be delivered to the school by the parent/guardian only and unused medication will be returned to the parent/guardian only. Medication not picked up by the parent/guardian within 3 days of notification will be disposed of by Administration or their designee.

I (we) agree to deliver a school month's supply of medication to the school in the original container the first school day of each month unless other arrangements are made with Administration. We understand that the empty container will be returned home the last school day of each month with the students.

I (we) agree to notify the school immediately if:

1. We change physicians.
2. The medication or dose is changed.
3. The administration of the medication is to be terminated.

Signature/Date: ____ Daytime Phone: ___________________________

Signature/Date: ____ Daytime Phone: ___________________________

Authorized Person Receiving Medication: ________________________ Date/Time: _______________________________