CORNERSTONE
CHRISTIAN ACADEMY

Student Photo

Cornerstone Christian Academy

Prescription Medication Administration Form
Medications for School Time Administration

One student and medication per form only

School year: _____

Student Name: _____ Date of Birth: _____

Student Address: _____

Name of Medication: _____ Dose: _____

□ As Needed (frequency): every _____ hours □ Scheduled (time of day): _____

Reason for Medication: _____

Special Instructions: _____

Reasons to call parent/guardian: □ Anytime med is given □ Only if adverse effects noted

Possible adverse effects: _____

Physician/Healthcare Provider Name: _____ Phone: _____

Physician/Healthcare Provider Signature: _____

Parent/Guardian: I give permission for my child to receive the above medication at school according to the school policy. I agree I am responsible for:

- **Administering once daily medications at home. A small "just in case we forgot" supply may be kept at school.**
- **Providing medication that is <u>not expired</u> to the school in its original container.**
- **Telling the school as soon as possible if there is a change in how this medication is used.**
- **Obtaining a new form from the Physician/Healthcare Provider for each school year as well as if there are dosage changes.**
- **Picking up medication at the end of the school year. No medication will be released to students. Empty bottles <u>only</u> will be sent home with students.**

I agree for my child's healthcare provider to talk with school staff about this medication if needed. No other part of my child's medical record will be discussed if it does not pertain to this medication.

Parent/Guardian Signature: _____ **Date:** _____

Phone: _____ **Alt. Emergency Phone:** _____