CORNERSTONE CHRISTIAN ACADEMY

Student Photo

Medication Administration Form
Over the counter/Non-Prescription

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: _____
(ex: for pain/fever, for indigestion, etc. Reasons do NOT need to be specific, can be more generalized)

Special Instructions: _____

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

Possible adverse effects: _____

Physician/Healthcare Provider Name: _____ Phone: _____

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 the over-the-counter medication I want administered to my student, ensuring it is not expired and will not expire prior to the end of the school year, and it is in its original container.**
- **Telling the school as soon as possible if there is a change in how this medication will be used.**
- **Completing a new form 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 only will be sent home with students.**

I authorize 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: _____

FOR STAFF USE ONLY: Family Supply: _____ Grade Bin Loc: _____

Student Med Bag: _____