Request for Medication Administration

To be completed by parent/guardian

Student Name: _____ Date of Birth: _____

Address: _____ Phone: _____

Parent(s)/Guardian(s): _____

Emergency Contact: _____

Medication to be administered: _____

Dosage: _____ Time to be administered: _____

Reason for medication: _____

Presenting physician: _____ Phone: _____

Allergies: _____

Comments: _____

I request that Conway Christian School administer the medications listed above to my child in accordance with my request and/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 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 not be held responsible for any undesired reaction that may occur as a result of taking this medication. The school nurse has my permission to consult with my child's physician regarding his/her medical condition. In accordance with "Alex's Law," 6-18-707, I understand that my signature below allows my child to carry and administer any prescribed inhaled bronchodilators and auto-injectable epinephrine unless otherwise noted in the comments area of this release form.

Parent/Guardian(s) Signature: _____

Date: _____