

MEDICATION PERMISSION REQUEST FORM

Note to Parents/Guardians:

Christ the King H.S. requires that all students who need medication during school hours must complete this form and bring the medication in the original prescription bottle, properly labeled by a registered pharmacist as prescribed by law.

NAME OF STUDENT _____

DATE OF BIRTH _____

THE FOLLOWING IS TO BE COMPLETED BY PHYSICIAN:

DIAGNOSIS: _____

MEDICATION: _____

DOSAGE AND ROUTE OF ADMINISTRATION: _____

SELF ADMINISTRATION ORDERS – if indicated: _____

FREQUENCY AND TIME OF ADMINISTRATION: _____

DURATION: _____

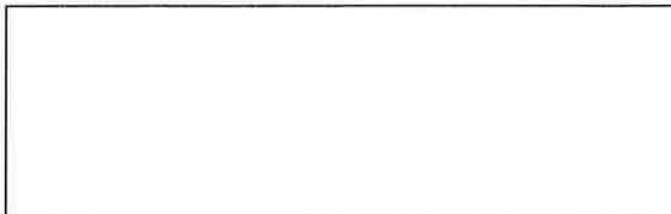
FOR PRN MEDICATIONS – CONDITIONS UNDER WHICH MEDICATION SHOULD BE
ADMINISTERED: _____

DATE ORDER WRITTEN: _____

PRESCRIBER'S SIGNATURE: _____

PRESCRIBER'S TELEPHONE NUMBER: _____

PHYSICIAN'S STAMP



TO BE COMPLETED BY PARENT:

I, _____ give permission for my child to receive the above medication as directed.

Date: _____ Parent's Signature _____ Telephone # _____

FAX TO ATTENTION: NURSE (718) 366-1165 OR MAIL