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