

Citadel Christian School
Request for Prescription Medication Administration
{ to be completed by parent or guardian }

Student Name: _____ Birthdate: ____/____/____

Address: _____

Parent/Guardian Name: _____ Phone: () ____ - ____

Emergency Contact: _____ Phone: () ____ - ____
(to be contacted after the parent/guardian)

Physician Name & Affiliated Medical Center:

Medical Center Address: _____

Medication(s) to be administered: _____

Dosage to be administered: _____

Time/interval at which each dosage is to be administered: _____

Date to begin administration: _____

Date to cease administration: _____

I request that **Citadel Christian School** administer the above medication to my child in accordance with my request and the physician's statement of need. I agree to personally deliver and pick up any medication. I understand that sending medication with a student is not acceptable. I agree to notify CCS 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 CCS in its original container. I understand that any medication provided to CCS in any container other than the original will not be accepted. I understand that CCS will have limited liability while administering medication to my child in accordance with a physician's statement of need. I understand that CCS will keep a written log of medication administered to my child by their Faculty or Staff members throughout the current school year.

Parent /Guardian Signature

Date