NEW HOPE CHRISTIAN ACADEMY

This form must be completed with physician and parent/ guardian signatures. The required written information must be received BEFORE any medication can be administered at school.

Parent Permission Date:_____

Student's Name:_____ Birth date:_____

Address:_____ Home Phone:_____

Grade Level:_____ Homeroom Teacher:_____

I hereby request and give permission for the SCHOOL NURSE or his/her DESIGNEE to administer the medication as described below and to communicate as needed with the parents or prescribing physician. I understand that I am responsible for delivering the prescribed medication to the student's school in its original container (as labeled from the pharmacy) and for assuring that an adequate supply of the medication has been provided to the school.

Parent Signature:_____

Physician's Direction

The above named student is under my care and should receive the following:

Medication:_____ Dosage:_____ Route:_____

At these times:_____

Side Effects that need attention:_____

Other specific instructions for administration:

Expiration date of this request:_____

Doctor requests teacher's comments

- ❑ Yes: Please observe the following:_____
- ❑ No: Teacher comments unnecessary

Physician Name (please print or type):_____

Physician signature:_____

Physician Phone Number:_____ Physician Fax Number:_____

Date:_____