Request for Prescription Medication Administration

Student: _____ DOB _____ Grade: _____

List any food or drug allergies: _____

Medication: _____ Dose: _____

Take medication: ☐ by mouth ☐ via inhaler ☐ topical (cream) ☐ injection ☐ other _____

Condition for which medication is given: _____

To be given: ☐ Entire School Year - or - ☐ The following dates: ___ /___ /____ to: ___ /___ /____

When: ☐ At the following time(s): _____ - or - ☐ As needed every _____ hours

Special Considerations/side effects: _____

For Daily Medications: ____ Yes, please send on field trips

____ No, please do not send on field trips

Parent/Guardian: I give permission for the Lubbock Christian School nurse or other trained personnel to administer medication to my child in accordance with school policies and guidelines and physician orders. I understand that Lubbock Christian, the Board and its employees shall be immune from civil liability due to allergic reaction or other injuries resulting from administration of medicine to a student, provided such administration conforms to the requirements of this policy. It is the responsibility of the parent/guardian to maintain medication supply. Medications should be brought directly to the school nurse and not sent to school with students. Unclaimed medication will be destroyed at the end of the school year.

Parent Signature: _____Date: _____

Printed Name: _____ Phone: _____

School: Medication was received by: _____ Date: _____

Signature: _____ Quantity Received: _____