CHRIST THE KING SCHOOL

195-B BRANDON ROAD ♦ PLEASANT HILL, CA 94523 ♦ (925) 685-1109 ♦ FAX: (925) 685-1289

REQUEST FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS

TO BE COMPLETED BY PARENT/GUARDIAN: (For ALL medications)

I/we requested that authorized persons assist my child, named below, in taking the prescribed or over-the-counter medication at school and will comply with the school's policies and procedures. I have provided the medication in its original, labeled container.

Signature of Parent/Guardian:_____ Day Phone:(____)_____

STUDENT: _____ **GRADE:** _____ **DATE:** _____

NAME OF MEDICATION: _____ **DOSE:** _____

BEGINNING DATE: _____ **ENDING DATE:** _____ **TIME(S) TO BE GIVEN:**_____

REASON FOR GIVING THIS MEDICATION:

_____

TO BE COMPLETED BY A LICENSED PHYSICIAN: (For ALL prescriptions and ASPIRIN)

_____ _____

Name of Medication Purpose of Medication

_____ _____ _____

Dosage Prescribed **Time Schedule** **Dose Form (tablet, liquid, etc.)**

_____ _____

Date of Prescription **Length of Time This Medication Necessary**

PRECAUTIONS, SPECIAL INSTRUCTIONS, POSSIBLE ADVERSE EFFECTS, COMMENTS:

_____

_____

_____

The student named above, for whom this medication is prescribed, is under my care.

Print Name of Physician _____ **Signature of Physician** _____

Telephone Number _____ **Date** _____

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TO BE COMPLETED BY PERSONNEL: For every different initial print name and signature.

Initial	Print Name	Signature

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MEDICATION LOG

STUDENT NAME _____ School Year _____ Grade _____

Name of Medication _____ Dosage _____

Student Signature:	Student Initials:

DATE	TIME	STUDENT INITIALS	WITNESS INITIALS	DATE	TIME	STUDENT INITIALS	WITNESS INITIALS

THIS FORM MUST BE COMPLETED FOR EACH MEDICATION TO BE ADMINISTERED AND RENEWED EACH YEAR.