



**ELIM CHRISTIAN SCHOOL
PRESCRIPTION MEDICATIONS
AND
APPROVED O.T.C. MEDICATION ORDER**

(TO BE COMPLETED BY PHYSICIAN)

Child's name _____ Birth date _____

This child is under medical care for _____ and

medication is required during the school day

for _____.

Please list all prescription medications that this child is currently taking.
Medications to be administered during the school day must be included.

Name of drug	Dosage	Route	*Time/Indication	Duration	Side Effects

Prescriber name (please print) _____ Phone (____) _____
FAX # (____) _____

Prescriber signature _____ Date _____

****Administration of medication during school hours is only available during the following times****

11:00 a.m. Student's Lunch 1:30 p.m.

(TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN)

I _____, give permission for a registered nurse or designated school personnel to administer the prescribed medications listed above as directed by the prescriber. I understand that the medication must be sent in an *accurate*, pharmacy labeled container. I understand that I am responsible for supplying my child's medication. I will ensure that the medication is refilled promptly when requested. I understand that all medication must be sent in its original form and with at least one week's supply.

I understand that a new medication order is required if there are any changes or additions to the medications listed above. I will notify the school, in writing, if the medication is discontinued.

Parent/guardian signature: _____ Date: _____

Completed forms may be faxed to (708) 293-2355 or emailed to nurse@elimcs.org

(Revised 04/07/2016)