 **ELIM CHRISTIAN SCHOOL**

**PRESCRIPTION MEDICATIONS**

**AND**

**APPROVED O.T.C. MEDICATION ORDER**

**(TO BE COMPLETED BY PHYSICIAN)**

Student’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This student is under medical care for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ . Medication is required during the school day to treat\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

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** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**Physician’s name (please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FAX # (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician’s 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 (i.e. uncut) 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 04/12/2019)**