Elim

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)