ELIM CHRISTIAN SCHOOL

PRESCRIPTION AND APPROVED O.T.C. MEDICATION ORDER

(Revised 4/5/24)

TO BE COMPLETED BY PRESCRIBING HEALTH CARE PROVIDER

Date:_____

Student's Name:_____ Birthdate:_____

Medication is required during the school day for the treatment of:_____

_____

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

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

Physician's name: (please print) _____ **Phone: (_____)** _____

Physician's signature:_____ **Fax: (_____)** _____

***Administration of medication during school hours must be scheduled is only available during the following times:**

11:00 a.m. Student's Lunch Time 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 and over-the-counter 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 student'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, undiluted**) 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 nurse, in writing, if the medication is to be discontinued.**

Parent/Guardian Signature: _____**Date:** _____

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