GRACE
CHRISTIAN ACADEMY
Academic Excellence. Amazing Grace.

REQUEST FOR MEDICINE ADMINISTRATION

Student Name _____ Birthdate _____ Grade _____

Address_____ City _____ Zip _____

Parent/Guardian_____ Phone Number _____

Emergency Contact Information _____

Medication to be administered
_____

❑ Over the Counter Medicine ❑ Prescription Medicine

Dosage to be administered _____

Time or intervals dosage is to be administered _____

Name of Physician prescribing medication _____

Address _____ Phone _____

Date to begin administration _____

Date to cease administration _____

Additional instructions or information _____

_____

_____

_____

I request Grace Christian Academy to administer the above medication to my child in accordance with the physician's specifications and/or my request. I agree to notify the school in writing of any changes in the administration of medication or the information provided on this form. I understand it is my responsibility to send in an appropriate amount of medication to the school and that it must be in its original container. Any medication provided that is not in an original container will not be accepted. I understand that the school will have limited liability while administering medication to my child in accordance with the physician's specifications. The school will keep a written log of any medication they administer to my child throughout the current school year.

_____ _____
Parent/Guardian Signature Date of Request