NEW COVENANT
CHRISTIAN SCHOOL

PHYSICIAN'S PRESCRIPTION AUTHORIZATION

Parents have the primary responsibility for the health of their child. Whenever possible, medications should be taken at home. However, if students must receive medication during the school day, the following will apply:

1. Parents and the child's physician will be required to complete this form.
2. The School Nurse or designated school personnel will dispense medication according to the physician's written orders.
3. All medication must be labeled correctly. The label must include name of student, drug, dosage, frequency and time of administration, pharmacy's name and address, the date and the prescription number. This is also required for inhalers. Labeled medication is stored in the Health Room in a secure place for the period indicated on the physician's order.
4. Parents are responsible to ensure that needed prescription refills are supplied to the School Nurse.
5. At the end of the school year the parent is expected to pick up unused medication. Medication not picked up by a parent will be destroyed.
6. Medication must be delivered by a parent/guardian and brought directly to the School Office. **Students are not permitted to carry medication to or from school, or while in school.**

TO BE COMPLETED BY THE PARENT

Child's Name: _____ Birth Date: _____

I request that the medication for my child be stored or administered as indicated in the Physician's order below. I am aware that non-medical personnel may be administering this medication to my child. I hereby release New Covenant Christian School and all its employees from any and all liability in law for damages either we or our child may suffer as a result of this request.

Parent's Signature: _____ Date: _____

Home #: _____ Cell #: _____ Work #: _____

TO BE COMPLETED BY THE PHYSICIAN

It is necessary that the named child receive the following medication at the times as directed. Please store and administer the medication according to the following instructions:

Name and form of the medication: _____

Dosage: _____ Times to be given: _____ Duration: _____

Other specific directions: _____

Purpose of medication and/or diagnosis: _____

Other medications prescribed by the physician that the student is taking outside of school hours: _____

_____

Common side effects and contraindications: _____

Curtailment of specific school activity (sports, etc.): _____

_____

Print Physician's Name: _____ Phone: _____

Physician's Signature: _____ Date: _____