

REQUEST FOR SCHOOL PERSONNEL TO ADMINISTER  
**OVER-THE-COUNTER MEDICATION**  
(Only **ONE** medication per form)

**SCHOOL YEAR 2009-2010 ONLY**

STUDENT INFORMATION

Name: \_\_\_\_\_ Grade: \_\_\_\_\_  
Age: \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Weight: \_\_\_\_\_

PRESCRIBING PHYSICIAN TO COMPLETE THIS SECTION

**Physician's name:** \_\_\_\_\_ **Phone number:** \_\_\_\_\_  
(please print)

I direct Front Range Christian School to administer to the above listed student:

Name of medication: \_\_\_\_\_

Dosage: \_\_\_\_\_

By what route: \_\_\_\_\_ Frequency: \_\_\_\_\_

Symptom/condition for use: \_\_\_\_\_

Period of time for use (max one school year): \_\_\_\_\_

Are there potential adverse effects? **Circle one:** YES NO

If YES, please explain: \_\_\_\_\_

**Physician's signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

PARENT TO COMPLETE THIS SECTION

I authorize Front Range Christian School to administer the above listed over-the-counter medication to my child, as directed by the prescribing physician and manufacturers directions, when he/she expresses the indicated symptom/condition listed above. If the prescription is for a dosage that exceeds or differs from the dosage recommended by the manufacturer, this form will be invalid by nature of the fact that this dosage is considered prescription strength and does not meet the criteria of an over-the-counter medication. I am submitting to FRCS this form completed in its entirety, the medication in its original container, and a **metered measuring utensil if applicable.**

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

School Nurse Verification \_\_\_\_\_

REQUEST FOR SCHOOL PERSONNEL TO ADMINISTER  
**PRESCRIPTION MEDICATION**  
(Only **ONE** medication per form)

**SCHOOL YEAR 2009-2010 ONLY**

STUDENT INFORMATION

Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Age: \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Weight: \_\_\_\_\_

PRESCRIBING PHYSICIAN TO COMPLETE THIS SECTION

**Physician's name:** \_\_\_\_\_ **Phone number:** \_\_\_\_\_  
(please print)

I direct Front Range Christian School to administer to the above listed student:

Name of medication: \_\_\_\_\_

Dosage: \_\_\_\_\_

By what route: \_\_\_\_\_ Frequency: \_\_\_\_\_

Symptom/condition for use: \_\_\_\_\_

Period of time for use (max one school year): \_\_\_\_\_

Are there potential adverse effects? **Circle one:** YES NO

If YES, please explain: \_\_\_\_\_

**Physician's signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

PARENT TO COMPLETE THIS SECTION

I authorize Front Range Christian School to administer the above listed prescription medication to my child as directed by the prescribing physician. I am providing the prescribed medication in its original pharmacy-labeled bottle, **a metered measuring utensil if appropriate**, and this form completed in its entirety.

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If this medication is an asthma inhaler, EpiPen or other rescue-type medication, the student may self-carry and self-administer the medication on an as needed basis. If you give permission for your child to do this and accept sole responsibility for your child's use or misuse of the medication, please sign below. By signing below, you also acknowledge that misuse of this privilege will mean withdrawal of the privilege.

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

School Nurse Verification \_\_\_\_\_