HEALTH SERVICES

Scofield Christian School

2024-2025

Parent/Physician Request for Administration of Medication by School Personnel

Date of Request: _____

Student's Name: _____ Birth date:_____/_____/_____

Medication:_____Exp. Date:____/____

Dosage:_____

Route of administration:

☐ by mouth ☐ inhaled ☐ topical ☐ eye(s) ☐ ear(s) ☐ nasal ☐ other:_____

Time to be administered:_____ Dates to be administered:_____

Condition for which medication is required:_____

Has your child ever taken this medication before: Yes No

Medication Allergies: ☐ No Known Medication Allergies ☐ Allergic to:_____

Special Instructions/Precautions/Side Effects of medication on your child:_____

_____

Physician's Name:_____ Phone (_____)_____-_____

Physician's Signature:_____

My signature below indicates that I request that Scofield Christian School staff administer the medication specified above to my child, and I am giving permission for SCS staff to contact the physician for additional information, if needed.

Parent/Guardian Signature:_____

Email:_____

Parent's Daytime Phone: (_____)_____-_____

Parent's Cell Phone: (_____)_____-_____

Please use separate form for each medication.

Bring Request Form & Medication in Ziploc Bag labelled with student's name to the school office.