Parental Request & Physician's Order for Prescription and Over-the-Counter Medication
2023-2024

Parents have the primary responsibility for the health of their child. As a general rule, if at all possible, medication should be taken at home. If parents wish to delegate some part of their responsibility to the school, the following will apply:

- Parents and physician must complete this Parental Request & Physician's Order for Medication form. A physician's signature is required for prescription medication.
- All medication must be sent in the original, labeled container.
- Office staff (unlicensed, competent adult) will dispense medication according to the physician's order.
- Medication will be stored in a secure place for the period indicated on the physician's order.
- Early childhood & lower school students are not permitted to keep any medication, including over-the-counter, in their lockers or on their person during school hours.
- Middle & upper school students may carry their own OTC medications for headaches, etc., but must submit the Parental Request and Physician's Order for Medication form to the office.
- At the end of the school year, the parent must pick up unused medication. Medication not picked up by the last day of school will be destroyed.

To be completed by Parent/Guardian:

Child's Name: _____ Date of Birth:_____

I request that medication for my child (named above) be stored or administered as indicated in the physician's order below. (If over-the counter-medicine then physician's signature not required, but dosage and times to administer must be included on the medication.) We hereby release Lancaster County Christian School and all of its employees of and from any and all liability in law damages either we or our child may suffer as a result of this request.

Parent/Guardian Signature_____ Date: _____

Primary Phone: _____ Work Phone: _____

To be completed by Physician:

IT IS NECESSSARY THAT THE NAMED CHILD RECEIVE THE FOLLOWING MEDICATION AT THE TIMES STATED. PLEASE STORE AND ADMINISTER THE FOLLOWING AS DIRECTED BELOW:

Name and form of medication: _____ Dosage: _____

Time(s) medication is to be given: _____

Route of administration: _____

Other specific directions: _____

Purpose of medication and/or diagnosis: _____

Side effects to watch: _____

Duration of order: _____

Physician's name (Print): _____ Phone: _____

May student have inhaler with him/her at all times? ☐ Yes ☐ No

Parent/Guardian Signature_____ Date: _____

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