REQUEST FOR MEDICATION ADMINISTRATION
(TO BE COMPLETED BY PARENT/GUARDIAN)

PLEASE PRINT

Child's Name: _____ Birth Date: _____

Address: _____ Phone: _____

Parent/Guardian: _____ Daytime Phone: _____

Emergency Contact Information: _____

Medication to be administered: _____

Dosage to be administered: _____

Time or interval in which dosage to be administered: _____

Name of physician authorizing administration: _____

Address: _____

Phone: _____

Date to begin administration: _____

Date to cease administration: _____

I request that First Baptist Academy, administer the above medication to my child in accordance with my request. I agree to notify the school in writing of any changes in my child's condition with respect to the administration of medication or with any changes to the information provided on this form. **I understand that it is my responsibility to send an appropriate supply of medication to school in its original container. Medication provided to the school in any container other than the original will not be accepted. This container must also be labeled with the child's name and dosage to be administered. If it is a prescription medication, it must be labeled by the pharmacy.**

I understand that the school has limited liability while administering medication to my child in accordance with the *Physician's Statement of Need*. The school agrees to keep a written log of medication administered to my child in school throughout the current school year.

Guardian Signature: _____ Date: _____