Delmarva Christian High School
Prescription Medication Administration Form

If it is necessary for your child to receive prescription medication during the school day, please note the following:

- Send the medication to school with a responsible individual if you are unable to take it to school.
- Send the medication in the original container. The container must be properly labeled with correct name, time, dose, date, and prescribing licensed healthcare provider.
- Count the tablets (unless the number of tablets is the exact number on the label) or approximate amount of liquid in the bottle.
- Pick up any remaining medication from school at the end of the school year.

Date _____

Student's Name: _____

Medication: _____

Dose: _____ Time: _____

Reason for Medication: _____

Allergies to any medications: _____

Number of tablets sent: _____

Amount of liquid: _____

I am aware that the school nurse may need to contact the prescribing healthcare provider or pharmacist relative to the medication/treatment and that the school nurse is required to use nursing judgment regarding all medication administration. I give my permission for medication administration by the Delmarva Christian High School nurse.

Parent/Guardian Signature: _____

Nurse's Signature: _____

Number of tablets/amount of liquid received: _____