Delaware Christian School
Permission to Dispense Medication Form

****Only for medications that must be administered during school hours****

Student's Name______________________________________ Grade_____

Non-Prescription Medications

My child has permission to take the following over-the-counter medications (i.e. Tylenol, Advil, Sinutab, Pepto-Bismol, etc.):

Name of medication:	Dosage
_______________________________________	__________
_______________________________________	__________
_______________________________________	__________
_______________________________________	__________

Prescription Medication
(To be completed by the child's physician)

Child's name:___________________________________Date of birth:______________

Name of medication: _________________________ ___ Date of authorization:____________

Reason for medication: ____

Dosage_____________ Frequency______________ How administered_________________

Date to begin administering medication_______________ Date to terminate______________

Time(s) to be given at school (exact time):______________________________________

Possible side effects/adverse reactions:____

Physician______________________________Telephone #______________________

Address____

Physician's signature____

Must be completed by the parent:

The undersigned agrees not to file or make any claim against anyone for negligence in connection with administration or non-administration of any medicines and further agrees to save such individuals and hold them harmless from any liability incurred as a result of the administration or non-administration of any medicines. I request school personnel to administer the medication as instructed and agree to (1) deliver the medication to the school in the original container from the pharmacist with the label showing the child's name, dosage directions, doctor's name and prescription number and (2) notify the school if I change physicians or if the medication is changed or eliminated. I understand it is the student's responsibility to report on time for this medication. I understand that students may not administer over-the-counter medications to themselves or others, including, but not limited to: pills, lotions, Advil, Tylenol, etc.

I give my permission for the principal or his/her designee to administer the aforementioned medications listed.

Signature of Parent or Guardian____________________________________Date ______________

Daytime Telephone #________________________