Delaware Christian School
Permission to Dispense Prescription Medication Form for 2024-2025 School Year

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

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

Child's name:_____Date of birth:_____

Address of Child:_____Grade/Teacher:_____

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:_____

Special storage instructions:_____

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 #_____