Denbigh Baptist Christian School

Medication Administration Form

Short-Term (10 school days or less)

Instructions:

- The parent/guardian must provide the medication and bring it to the office. **Students must not carry/bring the medication to school.**
- **Over-The-Counter** (OTC) medication must be packaged in the original, unopened container.
- **Prescription** medication must be labeled with the child's name, the medication name, dosage, licensed health care provider's name, pharmacy name, and pharmacy phone number. For your convenience, please ask the pharmacist for a separate medicine bottle for home.
- The parent agrees to pick up expired/unused medication within one week of notification by the staff.
- The name of the medication MUST match the bottle and the form. (For example, if the name of the medication is Motrin, the bottle/form must say Motrin. It will not be accepted if it says Advil. The generic name is preferred.)

Section A: To be completed by Parent/Guardian

I authorize and request the school/childcare staff to give the following medication to my child.

Child's Name: _____

Name of Medication: _____

Dosage: _____ Time to be administered: _____

If medication is given prior to school hours, state time and dosage: _____

Starting Date: _____ Ending Date: _____

Parent/Guardian Signature: _____ Date: _____

Denbigh Baptist Christian School
Medication Administration Form
Long-Term Medications

Instructions:

- The parent/guardian must provide the medication and bring it to the office. **Students must not carry/bring the medication to school.**
- **Over-The-Counter** (OTC) medication must be packaged in the original, unopened container.
- **Prescription** medication must be labeled with the child's name, the medication name, dosage, licensed health care provider's name, pharmacy name, and pharmacy phone number. For your convenience, please ask the pharmacist for a separate medicine bottle for home.
- The parent agrees to pick up expired/unused medication within one week of notification by the staff.
- The name of the medication MUST match the bottle and the form. (For example, if the name of the medication is Motrin, the bottle/form must say Motrin. It will not be accepted if it says Advil. The generic name is preferred.)

Section A: To be completed by Parent/Guardian

I authorize and request the school/childcare staff to give the following medication to my child.

Child's Name: _____

Name of Medication: _____

Dosage: _____ Time to be administered: _____

If medication is given prior to school hours, state time and dosage: _____

Starting Date: _____ Ending Date: _____

Parent/Guardian Signature: _____ Date: _____

Section B: To be completed by Physician/Health Care Provider

I certify that it is medically necessary for the medication listed below to be administered to this child for a duration that exceeds 10 school days.

Child's Name: _____

Name of Medication: _____

Dosage: _____ Time to be administered: _____

Route: _____

Purpose of Medication: _____

Special Instructions: _____

Starting Date: _____ Ending Date: _____

Physician's Printed Name: _____

Physician's Signature: _____ Date: _____

Physician's Phone Number: _____ License Number: _____