LANCASTER COUNTY CHRISTIAN SCHOOL

PARENTAL REQUEST AND PHYSICIAN'S ORDER FOR PRESCRIPTION AND OVER THE COUNTER MEDICATION
(For students who require daily or as needed medication 2017-18 school year)

Parents have the primary responsibility for the health of their child. As a general rule, and if at all possible, medication should be taken at home.

If parents wish to delegate some part of their responsibility to the school, the following will apply:

- Parents and physician will be required to complete the form below. (Physician's signature required for prescriptions.)
- Office Staff (unlicensed competent adult) will dispense medication according to the physician's order.
- Labeled medication will be stored in a secure place for the period indicated on the physician's order.
- Elementary students are not permitted to keep any medications, including over the counter, in their lockers or on their persons during school hours. Middle and High School students may carry their own OTC medications.

At the end of the school year, the parent is expected to pick up unused medication. Medication not picked up by the last day of school will be destroyed.

TO BE COMPLETED BY PARENT/GUARDIAN:

Child's name: _____ Birth date:_____ Campus: _____

I request that medication for my child (named above) be stored or administered as indicated in the physician's order below. (If over the counter medicine then physician's signature not required, but dosage and times to administer must be included on the medication.) We hereby release Lancaster County Christian School and all of its employees of and from any and all liability in law damages either we or our child may suffer as a result of this request.

Parent's/guardian's signature: _____ Date: _____

Home telephone: _____ Work telephone: _____

TO BE COMPLETED BY PHYSICIAN:

IT IS NECESSSARY THAT THE NAMED CHILD RECEIVE THE FOLLOWING MEDICATION AT THE TIMES STATED. PLEASE STORE AND ADMINISTER THE FOLLOWING AS DIRECTED BELOW:

Name and form of medication: _____ Dosage: _____

Time(s) medication is to be given: _____

Route of administration: _____

Other specific directions: _____

Purpose of medication and/or diagnosis: _____

Side effects to watch: _____

Duration of order: _____

Physician's name (Print): _____ Telephone: _____

May student have inhaler with them at all times: ____ Yes ____ No

* Physician's Signature: _____ Date: _____

Fax 717-656-4868