Resurrection Academy

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To be completed by parent: (1 form per medication, including over-the-counter)

Name of Student: _____Grade:_____

Name of medication _____

Dose _____

Time(s) to be given _____

Number of days _____

I request that my child, named above, be assisted in taking the prescribed medication at school by authorized personnel. I agree to comply with the school's policies and procedures. I have provided the medication in its original container and labeled it as above.

_____ _____
Parent/Guardian Signature Date

Daytime telephone number _____

To be completed by a licensed physician: (1 form per medication, including over-the-counter)

_____ _____
Name of medication Purpose of medication

_____ _____ _____ _____
Date prescribed Dosage Frequency Duration

Precautions, special instructions, possible side effects, comments:

_____

_____

The student named above, for whom this medication is prescribed, is under my care.

_____ _____ _____
Print name of Physician Signature of Physician Date