Providence Christian School
Medication Consent Form

Name of Child___________________ DOB______Teacher___________________

Allergies____

Name/type of Medication____

☐ OTC Medication is in original container

☐ Prescription has label

Dosage to be given___________________Time to be given_____________ am/pm

Time of last dose_______________ am/pm
****It is important to give medicine at the indicated intervals. Please keep the office informed of the time your child received the last dose of their medicine each day.****

Medication should be given (i.e. route) ☐ by mouth/liquid ☐ by mouth/pill

☐ drop/ear ☐ drop/eye ☐ other

Type of calibrated measuring device provided ______________________________

Symptoms for which "as needed" medication should be given________________

____

Does medicine require refrigeration? __yes __no

Possible side effects ____

____

I hereby give permission for my child (named above) to receive medication during school hours.

________________________________	_____________________	_______________
Parent/Guardian Signature	**Phone**	**Date**

Providence Christian School
4906 Providence Road Charlotte, NC 28226

Medication Administration Record

Child's name________________ DOB________ Allergies____ Wt:___________

Phone number_________________________

Date	Time of last dose	Name/Strength of Medication	Original Container	Route	Time med. admin.	Given by/ signature	Staff member to observe for 2 hrs	Comments/ Observations

Upon completion of medicine:

Parents notified to pick up medicine on (date)_______________________ by____

Signature of parent_______________________________________

Medication disposed of 72 hrs after notification (how/where)____

Signature of staff member_______________________________ Witness signature____