EASTERN CHRISTIAN SCHOOL

To be completed by Parent/Guardian:

I give my permission to the school nurse, or other unlicensed assistive personnel (UAP) educated by the nurse, to administer the medication/procedure listed below to my child during regular school hours and at other times when my child is participating in a school related event. I hereby release Eastern Christian School Association and its employees from any liability for injuries or other damages which may result to the student from administration of this medication/procedure.

The medication is to be furnished by me and is to be Pharmacy labeled with the name of the medicine, the amount to be given, time of day to be taken.

Parent's/Guardian's Name (please print): _____

Signature_____ Date_____
(Parent/Guardian)

To be completed by Prescribing Health Care Provider:

NAME OF CHILD: _____ GRADE: _____

DIAGNOSIS: _____

NAME OF MEDICATION: _____

MEDICATION TO BE ADMINISTERED FOR THE PERIOD FROM _____ TO _____
(Date) (Date)

DOSAGE: _____

FREQUENCY & DIRECTIONS: _____

DESCRIPTION OF PROCEDURE: _____

PURPOSE OF DRUG/PROCEDURE: _____

POSSIBLE SIDE EFFECTS: _____

APPROPRIATE FOR DELEGATION TO UNLICENSED ASSISTIVE PERSONNEL _____YES _____NO

Signature: _____ Date: _____
(Health Care Provider)

Address: _____ Telephone: _____

_____