PROVIDENCE
CLASSICAL SCHOOL

REQUEST TO DISPENSE PRESCRIPTION MEDICATION

SCHOOL YEAR: _____

Family Last Name: _____

(Please Print Legibly)

To Be Completed by the Physician:

Since medication for the student listed below cannot be scheduled for other than school hours and the administration of such medication may be supervised by non-medical personnel, it is requested that the medication as indicated below be administered by the Head of School's designee.

Name of Student: _____ Birthday of Student: _____

Medication	Dosage	Prescription Start Date	Prescription End Date	Purpose

Possible reaction that, if they occur, should be reported to the physician: _____

_____

Any special instructions (e.g., storage): _____

Physician's Signature: _____ Date: _____

Physician's Phone Number: _____ Emergency Number: _____

To Be Completed by the Parent / Guardian:

- I request the medication to be administered to our child in accordance with the instructions of our physician, Dr. _____
- I understand that the administration of the medication listed above is to be dispensed under the supervision of the Head of School's designee.
- I understand that the medication is to be delivered to the school by the parent/guardian and unused medication will be returned to the parent/guardian only. Medication not collected by the parent/guardian within 3 days of notification will be disposed of by the Head of School's designee.
- I agree to deliver a school month's supply of medication (for ongoing prescriptions) in the original container the first school day of each month unless other arrangements are made with the Head of School's designee. I understand the empty container will be returned home the last school day of each month with the student.
- I agree to notify the school immediately if:
    - We change physicians.
    - The medication or dose is changed.
    - The administration of the medication is to be terminated.

Signature / Date: _____ Daytime Phone: _____

Authorized Person Receiving Medication: _____ Date/Time: _____