FAYETTEVILLE CHRISTIAN SCHOOL
PHYSICIAN'S SCHOOL MEDICATION FORM

TO BE COMPLETED BY MEDICAL PROVIDER

Student's Name: ______________________ Date of Birth: ______________ Grade: ______

Name of School: ____

The above named person is a patient currently under my medical care. Due to a medical condition, the medication listed below must be administered during regular school hours according to the following protocol:

Medication Name: ____

Medication Instructions (include time of day, dose, route, and frequency): ______________________

____

____

Please indicate if the medication has special storage requirements such as refrigeration or light: ______________

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Physician’s Signature: ______________________ Date: ______________

Physician’s Printed Name: ______________________

Office Phone: ______________________

Office Address: ______________________

City, State, ZIP: ______________________

MD Stamp

TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN

I understand that:

- All medications administered at school must be in a pharmacy-labeled prescription package that matches the FCS Physician’s School Medication Form.
- FCS does not have a school nurse; therefore, non-medical personnel will be administering medications.
- Parent/guardian is responsible for notifying coaches or BAC supervisory staff of the child’s health status and/or the need for medication.
- Medication not picked up by the end of June will be discarded.
- Parents are responsible for any recalls on medication.
- This consent is valid for the term of one year, or May 31st of the current year, whichever comes first.

RELEASE OF LIABILITY

I, ______________________, the parent/guardian of ______________________, enrolled at Fayetteville Christian School, realizing the importance of administering medication to my child as prescribed by the child’s physician, do hereby agree to relieve designated school personnel of and from any liability from any potential ill effects as a result of their dispensing medication prescribed by the child’s physician. I have discussed this with my physician and/or legal counsel (lawyer) and realize its ramifications, and thoroughly understand the meaning of these statements. I consent for the medical provider to disclose health or medical information regarding medication prescribed. I understand I may revoke this consent at any time, except to the extent action has been taken in reliance on it. This consent is valid until I revoke it in writing, or for the term of one year, or on May 31st of the current year, whichever comes first.

Parent/Legal Guardian Signature: ______________________ Date: ______________

Office Staff Signature: ______________________ Date: ______________