The Learning Castle & La Cañada Preparatory

Fax: (818) 952-8010

REQUEST FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS

Requirement for Administration of Medication

To be completed by a licensed physician

Physician Authorization

Child's Last Name _____ First Name _____ Birth Date _____

Name of Medication _____

Purpose of Medication _____

Dosage Prescribed _____ Time Schedule _____ Dose Form (Tablet, Liquid) _____

Date of Prescription _____ Length of time this medication will be necessary _____

Precautions, Special Instructions, Possible Adverse Effects, Comments:

_____

_____

_____

Date _____ Print Name of Physician _____ Signature of Physician _____

Address _____ Telephone _____

Parent Permission/ Release

My child's attendance at school is dependent upon his/her receiving medication during school hours. It is impossible for me to come to school to administer this medication. I hereby request that a member of the school staff designated by the Director assist in administering the prescribed medication to my child. The Learning Castle, Inc. dba The Learning Castle and La Cañada Preparatory, the faculty, the staff, and/or the volunteers are not responsible or liable for any reaction that may occur after giving my child medication.

Student's Name: _____

Prescribing Physician: _____

Name and Type Medication: _____

Dosage: _____ Time: _____

For office use only

Person designated to administer the medication: _____

Location for storage of medication: _____

Director's Signature _____

Date _____ Signature of Parent or Guardian Authorized to Sign for the Family _____