



West Highland Christian Academy 2025-2026

REQUEST FORM FOR ADMINISTERING OVER THE COUNTER & PRESCRIPTION MEDICATION AT SCHOOL

My student has my permission to take, upon request, the medication product that I have furnished and have **included** with this form in addition to Tylenol or Ibuprofen available in the office.

Our policy is that medication to be dispensed by school personnel is to be in its **original container**.

Prescription medication must also be in the **original container**, and include the pharmacy label with dosage information.

It is required by law that **NO** medication be dispensed without prior written consent of the parents.

Name of Student: _____ D.O.B.: _____

Address of Student: _____ City: _____ ST: _____ ZIP: _____

Name of medication: _____ Dosage (quantity): _____

Time of administration: _____ Special Instructions: _____

Date to begin and cease administering medication: Start: _____ Cease: _____

Special instructions (administration, storage, etc.): _____

If the student experiences difficulty in breathing or swallowing, vomiting, unconsciousness, seizures, shock or any other severe adverse reactions, please notify the physician immediately.

Physician's office number: _____ After hours: _____

Physician's signature: _____ (if a prescription) Date: _____

As the parent or guardian, I (we) agree to provide the medication to the Principal or his/her designee in the container in which it was dispensed by the physician or licensed pharmacist.

As the parent or guardian, I (we) agree to notify the school immediately if:

1. We change physicians.
2. The medication or dosage is changed.
3. The administration of the medication is to be terminated.

Signature of parent(s) or guardians(s): _____ Date: _____

Telephone number: Home: _____ Business: _____ Other: _____