Church Farm School | CFS

Inspiring Boys • Fulfilling Dreams

Prescription and Non-Prescription Medication Form

Student Name: _____ **Student DOB**: _____

Parent/Guardian Name: _____

**Please note: If the medication is for ADHD or similar, please designate if the medication is only to be administered on school days/weekends as needed or if it must be administered seven days per week. Students are not permitted to self-carry stimulant medications.*

Current prescription and non-prescription medications:

Medication 1: _____ Taken with food (Y/N): _____

Dose: _____ Route: _____ Time: _____

Self-carry and administer (Y/N): _____ (if yes, please complete Release for Self-Administration of Medication Form)

Reason for taking medication and any additional information for the school nurse:

_____

Medication 2: _____ Taken with food (Y/N): _____

Dose: _____ Route: _____ Time: _____

Self-carry and administer (Y/N): _____ (if yes, please complete Release for Self-Administration of Medication Form)

Reason for taking medication and any additional information for the school nurse:

_____

Medication 3: _____ Taken with food (Y/N): _____

Dose: _____ Route: _____ Time: _____

Self-carry and administer (Y/N): _____ (if yes, please complete Release for Self-Administration of Medication Form)

Reason for taking medication and any additional information for the school nurse:

_____

I give my permission to the school nurse or other authorized personnel to administer the above medication(s) to my child. Should a change in any of the above information occur, I understand that a revised form of written physician's statement and parent authorization must be submitted.

Parent/Guardian Signature: _____ **Date**: _____

Prescriber Name: _____ **Prescriber Phone**: _____

Prescriber Signature: _____ **Date**: _____