WEST COVINA CHRISTIAN SCHOOL
763 N. Sunset Avenue
West Covina, CA 91790
(626)962-7089 ~ (626)962-1589 Fax

TYLENOL/ASPIRIN MEDICATION RELEASE FORM

PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

Name of Student_________________________________ Birthdate_______________

Address____
street city zip

Physical condition for which medication is to be given. (If allergic in nature, please specify what type of reaction, i.e., localized, generalized, mild, severe.)

____

____

Medication PLEASE CHECK ONE

_______ Acetaminophen - 325 mg tablets (school supply)

_______ Your own (tylenol, advil, aspirin, etc.)

Dosage and method of administration_______________________________________

____

Possible reactions that need to be reported to the physician

____

Disposition of student following the administration of medication, i.e., rest, home, hospital, doctor's office, return to class.

____

____

The above medication cannot be scheduled for other than during school hours and such medication may be administered by school staff whenever necessary.

Physician's signature____

DEA #___________________________ License # _____________________

Address____

Date Request ___________________________ Phone_________________________

Medication to be continued as above until ____________________________________
date

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PRESCRIBED OR OVER-THE-COUNTER MEDICATION

PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

Name of Student_____________________________________Birthdate_______________

Address____
street city zip

Physical condition for which medication is to be given. (If allergic in nature, please specify what type of reaction, i.e., localized, generalized, mild, severe.)

____

____

Medication PLEASE FILL ONE IN

Prescription____

Cough Medication____

Creams/Ointments____

Other____

Dosage and method of administration____

____

Possible reactions that need to be reported to the physician_________________________

____

Disposition of student following the administration of medication, i.e., rest, home, hospital, doctor's office, return to class.

____

The above medication cannot be scheduled for other than during school hours and such medication may be administered by school staff whenever necessary.

Physician's signature____

DEA # _________________________________ License #_________________________

Address____

Date Request___________________________________ Phone_____________________

Medication to be continued as above until _______________________________________
date