

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

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