

MITCHELL ROAD CHRISTIAN ACADEMY

Request for Medication Administration
(To be completed by parent or guardian)

Student's Name _____ Birthdate _____
Address _____
City _____ State _____ Zip _____
Phone _____ Grade _____ Teacher _____

Father's Name _____ Daytime Phone _____ Mobile _____
Mother's Name _____ Daytime Phone _____ Mobile _____

Emergency contact: Name _____ Phone _____ Relationship _____
Emergency contact: Name _____ Phone _____ Relationship _____
Insurance Company _____
Policy Number _____

Name of Physician: _____ Phone: _____
Address of Physician: _____

My child can be given the following Non-prescription Medication: (please check all that apply)

- Jr. Tylenol Tylenol Jr. Motrin Motrin Advil Liquid Benadryl Benadryl Tablet
 Topical Benadryl Maalox or Mylanta Tablets Cough Drops Saline Eye Drops Tums

Prescription medication to be administered at school _____
Time or interval at which each dosage is to be administered _____

Medication administered on a regular basis at home _____

Any allergies or special medical conditions your child may have should be listed below. _____

I request that Mitchell Road Christian Academy administer the above medication to my child in accordance with my request and the physician's statement of need. I agree to notify the school in writing of any changes in my child's condition with respect to the administration of medication or with any changes to the information provided on this form. I understand that it is my responsibility to send an appropriate supply of medication to school in its original container. Medication provided to the school in any container other than the original will not be accepted. I understand that the school will have limited liability while administering medication to my child in accordance with a physician's statement of need.

Parent's Signature (required)

Date

I give authorization to MRCA to take my child to the nearest medical center in case of an emergency?

Parent's Signature (required)

Date