Elementary School 215-969-1579
High School 215-969-2404
School Fax 215-969-9732

Calvary Christian Academy
Medication Consent Form
School Year _____

Parental Consent

I,_____, request that school personnel administer this
(Please print guardian's name)
prescribed medication to _____ according to the attached
(Please print student's name)
instructions from his/her physician _____.
(Please print physician's name)

Name of drug: _____
Dosage: _____
Time to be given: _____
Reason/Medical condition: _____

Date_____ Parent/Guardian Signature_____

Physician's Consent

My patient, _____is being treated for

_____. It is necessary that he/she receive

this prescribed medication during school hours according to the following instructions:

Name of drug: _____
Dosage: _____
Time to be administered: _____
Length of time to be given: _____
Possible side effects: _____

Date: _____ Physician's signature: _____