

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 _____

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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: _____

