TEMPORARY CONSENT FOR THE ADMINISTERING OF MEDICATION

(PARENT COMPLETES TOP PORTION OF FORM AND BRINGS TO CCS)

I _____ give permission to _____
(Name of Parent or Guardian) *(Name of Staff)*

on staff at Champion Christian School to administer _____ of _____
(Dosage) *(Name of Medication)*

to my child,_____ at approximately _____
(Name of Child) *(Times due)*

on _____ for treatment of _____
(Dates - not more than one week) *(Reason for Necessity of Medication)*

_____/__/__
(Signature of Parent) (Date)

. . . . . .

STAFF MEMBER IS RESPONSIBLE TO SEE THAT THE FOLLOWING CRITERIA HAVE BEEN MET

1 Top half of form has been completed YES NO

2 Medicine is contained in a safety type container YES NO

3 An original prescription label is on medication YES NO

a) Name of child on label YES NO

b) Date of prescription on label DATE _____

c) Instructions on label consistent with top half of this form YES NO

4 Name of prescribing physician: _____

5 Telephone number of prescribing physician: _____

_____/_/__
(Signature of Staff) (Date)

Name of Insurance Company_____ Policy and/or Group #_____