Prescription Medication Request: Short Term

Student_____School_____

Note: Prescription Medication must be in the original container indicating the following information: student name, dosage, healthcare provider, pharmacy, date issued and prescription number.

Parent Statement:

- I request that the following prescription medication be given to my child named above for no more than 15 school days.
- For this condition_____
- I understand that only ***current*** medications will be given at the school.
- I understand that there is no school nurse and an FCCS school employee will administer the medication.
- I agree to defend and hold FCCS and FCCS employees harmless from any liability for the results of the medication or the manner, in which it is administred, and to defend and indemnify FCCS and its employees for any liability arising out of these arrangements.
- I will notify FCCS immediately if the medication is changed.
- ***I understand that this medication will be destroyed unless picked up by the end of the last student school day of the year.***

Medication_____ **Time/dosage to be given_____** **Begin Date_____** **Possible Side Effects_____** **Healthcare Provider Signature_____**	**Dose_____** **_____** **End Date_____** **_____** **Phone_____**

As parent/guardian of the above named student, I request that Faith Community Christian School give the above named medication to my child.

X_____

Parent/Guardian Signature

_____

Date