Summer Discovery 2017
Check one: ___ K-2 ___ 3-5 ___ 6-9

MADISON COUNTRY DAY SCHOOL
Phone: (608) 850-6000 Fax: (608) 850-6006

REQUEST FOR ADMINISTERING PRESCRIPTION MEDICINE

Physician's Statement: (Please state all instructions in language of lay person.)

I request that _____ receive the medication listed below for the
(Child's Name)

period from _____ to _____ .
(Date) (Date)

The medicine, which is to be provided by the parent in the original container from the pharmacy, should include the child's name, physician's name, name of the drug, dosage, times of day to be given, and the name and telephone number of the pharmacy.

Name of Drug: _____

Dosage: _____

Time of Day to be Given: _____
(If noon, please indicate if it should be given before or after lunch.)

Reason for Medication: _____

The following are specific conditions under which I should be contacted regarding the condition or reaction of the child receiving the medication:

_____

_____

Physician's Signature: _____ Print last name: _____

Date: _____ Telephone: _____ Fax: _____

Patient/Parent Statement:

I request that my child _____ receive the above mentioned medication according to the physician's orders as stated above. I give my permission to school personnel to contact my child's physician. I also agree to provide a new medication form if there is any change in the above orders.

I further agree to hold both Madison Country Day School and their authorized personnel harmless in any and all claims arising from the administration of this medicine.

Parent/Guardian Signature: _____

Date: _____ Daytime telephone: _____