



EASTERN CHRISTIAN  
SCHOOL

---

**To be completed by Parent/Guardian:**

I give my permission to the school nurse, or other unlicensed assistive personnel (UAP) educated by the nurse, to administer the medication/procedure listed below to my child during regular school hours and at other times when my child is participating in a school related event. I hereby release Eastern Christian School Association and its employees from any liability for injuries or other damages which may result to the student from administration of this medication/procedure.

The medication is to be furnished by me and is to be Pharmacy labeled with the name of the medicine, the amount to be given, time of day to be taken.

Parent's/Guardian's Name (please print): \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Parent/Guardian)

---

**To be completed by Prescribing Health Care Provider:**

NAME OF CHILD: \_\_\_\_\_ GRADE: \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_

NAME OF MEDICATION: \_\_\_\_\_

MEDICATION TO BE ADMINISTERED FOR THE PERIOD FROM \_\_\_\_\_ TO \_\_\_\_\_  
(Date) (Date)

DOSAGE: \_\_\_\_\_

FREQUENCY & DIRECTIONS: \_\_\_\_\_

DESCRIPTION OF PROCEDURE: \_\_\_\_\_

PURPOSE OF DRUG/PROCEDURE: \_\_\_\_\_

POSSIBLE SIDE EFFECTS: \_\_\_\_\_

APPROPRIATE FOR DELEGATION TO UNLICENSED ASSISTIVE PERSONNEL \_\_\_\_\_ YES \_\_\_\_\_ NO

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Health Care Provider)

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_  
\_\_\_\_\_