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| **Reason For Request:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***Note: Medication will not be dispensed until this form is completed by a medical professional.* |
| Child’s Name: |  | Date of Birth: |  |
|  |  |
| Provider’s Name: |  | Clinic Name**:** |  |
| Address:  |  | City: |  |
| State:  |  | Zip: |  | Phone #: |  |
| **To be completed by Health Care Professional:** |
| **Condition:** |  | **Diagnosed by:** |  | **Date:** |  |
| **Symptoms:** |  |
| **Medication:**  | [ ]  Will [ ]  Will not be administered at East Martin Christian School. |

East Martin Christian School

516 118th Avenue

Martin, MI 49070

Phone: 269-672-5722

Fax: 269-672-5736

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| **Medication must meet the following criteria to be distributed at school:**1. The Medication must be in the original prescription container with the label adhered.
2. A specific time is mandated to dispense medication (i.e. at 2 p.m., after all meals, before a meal).
3. Pharmacy’s name, physician’s name, child’s name, dosages and instructions, name and strength of medication, date of refill/prescription (must be current) is on label.
4. This form must be renewed if the prescription is changed in any way.

**Medication(s) Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Administration Instructions: Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_ Quantity: \_\_\_\_\_\_\_\_\_\_\_\_**  **Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ End Date: \_\_\_\_/\_\_\_\_/\_\_\_** **Storage Instructions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Special Equipment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Instructions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **School Restrictions:** | **Physical Activity** **[ ]  No/** **[ ]  Yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Diet: [ ]  No/ [ ]  Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Call Parent If: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Call 911 If: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **While Waiting for Help: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Signature of Physician / Date** | Signature of Parent (Guardian) / Date |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_ |

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| **EMCS Staff**  |
| **Staff Members:** | **Signature** | **Date** |
| **Teacher** |  | **\_\_\_\_/\_\_\_\_/\_\_\_\_** |
| **Principal** |  | **\_\_\_\_/\_\_\_\_/\_\_\_\_** |
|  |  | **\_\_\_\_/\_\_\_\_/\_\_\_\_** |
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