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MEDICATION TREATMENT FORM

Parent/Guardian Medication Consent Form With Physician's Order for Administration

Student Name _____ Grade _____ DOB _____
 School _____
 Physician _____ Hospital/Clinic _____
 Home # _____ Cell # _____ Work # _____

PHYSICIAN: In order for school personnel to administer the medication regime you have prescribed, please complete the following form. Please feel free to contact the school at 617-522-1841 should any questions arise.

Name & Dose of Medication	Form: Tablet, Pill, Capsule, Other	Number to be taken	Approximate time of day	Term Short/Long

Name of Medication and Side Effects:

Please indicate if medication above is PRN (as necessary) medication:

Conditions under which PRN medication should be given are:

Physician Signature: _____ Date: _____

PARENT/GUARDIAN: (Please fill out this portion of the form, after your child's physician has completed the top and return this form to the school office.)

- I hereby give my permission to school personnel designated by the school to give medication to my child according to the written instructions of the physician as shown above.
- I also hereby agree to give my permission to the school designee to contact the child's physician.
- I further agree to hold Parkside Christian Academy and all employees harmless in any and all claims arising from the administration of this medication at school.
- I agree to notify the school in writing at the termination of this request or when any change in the above is necessary.

 Parent/Guardian Signature Date