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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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