Attachment B

Trinity Christian School
Health Service Department
Parent Request for Medication Administration

Date: ________________ **Teacher:** _________________________ **Grade:**______________

Child's Name: ____ **Age:** _____________

Allergies ____

Condition being treated: ____

Parents Phone Number **Work:** ____________________ **Home:** _________________

Medication	**Dose**	**Time to be Administered**
_____________________________	______	______________________________
_____________________________	______	______________________________

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Special Instructions:

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It is the responsibility of the parents to relay this instruction to the teacher.

I hereby request the TCS Health Service Department to administer the above medication to my child.

Parent Signature: ____

<u>Medication to be given for more than 10 days needs a Physician's signature</u>