DAYSPRING
CHRISTIAN ACADEMY

2025-2026 School Year

Medication Consent (Prescription and Over the counter)

Dear parent/guardian: We understand that the administration of medication during the school day is sometimes unavoidable. Please note the following:

- For your child to receive any medication during the school day (Prescription or OTC), the information below must be completed by parent **and physician**.
- All medication must be provided by you and must be in the **original container with your child's name clearly marked.**
- For students older than 12 years of age, Dayspring will provide 200mg tablets of Ibuprofen and 350mg capsules of Acetaminophen; however, in order for your child to receive either of these medications, this form must be filled out by a physician and signed by the parent or legal guardian. No expired medication will be accepted.
- **Medication must be brought in by the parent/guardian**. Do NOT send medication in with the child.
- Dispensing of all medication is documented by the school nurse.

Parent/Guardian Consent:

- I give permission for my child, _____, to receive the medication listed below during the school day.
- I understand that the medication will be given by the school nurse according to my child's physician's directions.
- I understand that in the absence of the school nurse, other office staff members may administer the medication if needed.
- I agree to release DCA of any liability and hold DCA harmless for the administered of the medication noted below.

_____ _____

Signature of Parent/Guardian Date

Licensed Prescriber Medication Order:

Patient's Name _____

Name of Medication_____

Dosage_____Route_____ Time of Administration_____

Reason for Medication_____

Possible side effects/Interactions with other medications_____

_____

Physician Name_____Physician Signature_____

Date_____

(Additional medication orders are located on reverse side of this form)

Licensed Prescriber Medication Order:

Patient's Name _____

Name of Medication_____

Dosage_____Route_____ Time of Administration_____

Reason for Medication_____

Possible side effects/Interactions with other medications_____

_____

Physician Name_____Physician Signature_____

Date_____

Licensed Prescriber Medication Order:

Patient's Name _____

Name of Medication_____

Dosage_____Route_____ Time of Administration_____

Reason for Medication_____

Possible side effects/Interactions with other medications_____

_____

Physician Name_____Physician Signature_____

Date_____

Licensed Prescriber Medication Order:

Patient's Name _____

Name of Medication_____

Dosage_____Route_____ Time of Administration_____

Reason for Medication_____

Possible side effects/Interactions with other medications_____

_____

Physician Name_____Physician Signature_____

Date_____