

# WESTLAKE CHRISTIAN ACADEMY

275 South Lake St. Grayslake, IL 60030  
Phone: 847-548-6209 Fax: 847-548-6481



## REQUEST FOR ADMINISTRATION OF MEDICINE TO STUDENTS 2018-2019

### SECTION 1: TO BE COMPLETED BY PHYSICIAN

WCA requests that medication be scheduled so as not to be given at school if at all possible. Prescription and/or over the counter medications will only be administered by a WCA employee at school with a doctor's written order and written request from the Parents/Guardians.

Student Name \_\_\_\_\_ Birth date \_\_\_\_\_ Grade \_\_\_\_\_

**The following information is to be completed by the PHYSICIAN:**

**PRESCRIPTION MEDICATIONS:**

Name of Prescription Drug \_\_\_\_\_ Dosage \_\_\_\_\_ Time to be given \_\_\_\_\_

Number of days to be given \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

Side Effects \_\_\_\_\_

Purpose of this medication \_\_\_\_\_

**OVER THE-COUNTER MEDICATIONS:**

Name of Drug \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_ Time to be given \_\_\_\_\_

Name of Drug \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_ Time to be given \_\_\_\_\_

Name of Drug \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_ Time to be given \_\_\_\_\_

Name of Drug \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_ Time to be given \_\_\_\_\_

**I, the undersigned, understand that I am authorizing the use of all of the drugs listed above.**

Physician Signature

Date

Name of Physician (please print)

Phone

Address

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## REQUEST FOR ADMINISTRATION OF MEDICINE TO STUDENTS 2018-2019

### SECTION 2: TO BE COMPLETED BY PARENTS/GUARDIANS

**The Office has a limited supply of the following over-the-counter medications. If your child's physician is giving consent for any or all of these medications, they must be listed on this form.**

- Acetaminophen caplets (500mg)
- Ibuprofen (200mg)
- Tums Antacid (750mg)
- Junior Tabs (Acetaminophen 160mg)
- Menthol cough suppressant drops
- Benadryl spray for topical use (2% diphenhydramine hydrochloride)

**Will you be supplying the over the counter medication listed above? (please circle one)** YES NO

*If yes, the over the counter medications must be in their original container labeled with your child's first and last name. These medications may only be kept in the school office and used only for your child.*

#### Parental Waiver of Liability:

I herewith acknowledge that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize Westlake Christian Academy and its employees and agents, on my behalf and stead, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of Westlake), lawfully prescribed medication in the manner described above. I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against Westlake Christian Academy, its employees and agents arising out of the administration of said medication. In addition I agree to hold harmless and indemnify Westlake Christian Academy and its employees, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication. Westlake Christian Academy retains the discretion to reject requests for the administration of medication.

**I request that Westlake Christian Academy make provision for my child \_\_\_\_\_**

**to receive the medicine according to the instructions listed on this form.**

Parent/Guardian Signature

Date

Name of Parent/Guardian (please print)

Daytime Phone

**Additional information:**

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