Prescription Medication Form (PMF)
(Physician Statement of Need)
High Point Christian Academy 2024-2025

Student Name _____ Birth Date _____

Classroom / Homeroom Teacher Name _____

This form shall be completed for all prescription medications that are to be administered by the school nurse or designee. The medication is to be hand-carried to the office by the parent/guardian and must be in its original pharmacy-labeled container. Please do not send medications with the student or give any medications to teachers. Please refer to High Point Christian Academy medication policy found in the student handbook for further information (Handbooks are found on our website www.hpcacougars.org).

PHYSICIAN STATEMENT OF NEED (This box to be completed by the physician.)

Name of Medication (include generic and trade name):

_____

Dosage (amount to be given):

_____

Time(s) to be taken at school: _____

To be given from (date) _____ to (date) _____

Reason for medication: _____

Side effects (expected or predictable):

_____

Prescribing Physician's Name (Print): _____

Office Phone: _____

_____ _____

PHYSICIAN SIGNATURE Date

PARENT'S PERMISSION

- I hereby give permission for my child (named above) to receive medication during school hours in accordance with my request and the physician's statement of need.
- I agree to notify the school in writing of any changes in my child's condition with regards to the administration of this medication or with any changes to the information provided on this form.
- I hereby authorize the school nurse to share this information with High Point Christian Academy staff as necessary for the safety and welfare of my child during the school year.
- I do hereby release High Point Christian Academy from any liability that may result from the prescribed medication.

_____ _____

PARENT/GUARDIAN SIGNATURE Date

Reviewed 05/17/2024