

PHILADELPHIA-MONTGOMERY CHRISTIAN ACADEMY
35 HILLCREST AVENUE
ERDENHEIM, PA 19038

MEDICATION CONSENT FORM
SCHOOL YEAR _____

****Important: Both Parental & Physician's portions must be filled in and signed in order for medication to be administered.***

→PARENTAL CONSENT

To: Don Beebe, PMCA Head of School
School Administrator/School Nurse

I, _____, request that school personnel administer this
Please print parent/guardian's name

prescribed medication to _____ according to the
Please print student's name

below directions from his/her attending physician, _____:
Please print physician's name

Date _____ Parent/Guardian Signature _____

→PHYSICIAN'S CONSENT

My patient, _____, is being treated for
_____. It is necessary that he/she receive this
prescribed medication during school hours according to the following directions:

Name of Medication _____

Dosage _____

Time to be Given: _____

Reason/Medical Condition: _____

Length of Time to be Given _____

Possible Side Effects _____

Date _____ Physician's Signature _____

Physician's Name Printed _____

Telephone