River City Christian School
Diagnosis and Prescribed Medication – RCCS PHYSICIAN FORM (to be completed by physician)
2024-2025 School Year

TAKE THIS FORM TO THE PRESCRIBING PHYSICIAN TO COMPLETE AND SIGN
(Doctor's office may be contacted for clarification)

This DIAGNOSIS AND PRESCRIBED MEDICATION FORM must be completed and signed by the student's physician. The Parent/guardian must also sign. Please return this completed and signed form to the RCCS nurse or office personnel. The parent must deliver medication with a prescription label directly to the school nurse or office personnel.

Student's Name: _____ Date of Birth _____
Physician Name: _____ Phone_____

Physician's Diagnosis and Health Care Information

Please provide the student information **in the second column** where applicable; if not applicable indicate by N/A:

Date of Last Physical Exam	
Diagnosis	
List any physical restrictions and length of time for restrictions	
Indicate No PE, recess, other activities	
List specific procedures during school hours, if any	
Emergency Instructions	

LIST ALL PRESCRIBED MEDICATION

Name of Medication	Dosage	Frequency of Doses	Indicate at Home or School
1.			
2.			
3.			
4.			
5.			

Length of time
_____
Any Restrictions?
_____

Physician's Signature _____ Date_____

Physician's Printed Name_____

_____ Date_____
Parent/Legal Guardian Signature (Father)

_____ Date_____
Parent/Legal Guardian Signature (Mother)