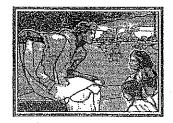
CHATHAM CENTRAL SCHOOLS



Authorization for Administration of Medication

4.	To be completed by the parent or guardian:
	I request that my child, grade receive the
	medication as prescribed below by our licensed health care prescriber. The medication is to
	be furnished by me in the properly labeled original container from the pharmacy. I understand
	that the school nurse, or other designated person in the case of the absence of the school nurse,
	will administer the medication.
	Signature (Parent or Guardian):
	Address:
	Address:
	Telephone: Home: Date:
	Work:
В.	To be completed by the licensed health care prescriber:
	I request that my patient, as listed below, receive the following medication:
	Name of Student: Date of Birth:
	Diagnosis:
	Name of Medication:
	Prescribed Dosage, Frequency and Route of Administration:
	Time to be Taken During School Hours:
	Duration of Treatment:
	Possible Side Effects and Adverse Reactions (if any):
	Other Recommendations:
	Name of Licensed Prescriber & Title (please print):
	Prescriber's Signature:
	Address: Phone:
	Date