CHATHAM CENTRAL SCHOOLS

Authorization for Administration of Medication

A. 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: _____

_____

Telephone: Home: _____ Date: _____

Work: _____

B. 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: _____