The School District of the Chathams
School Health Services

SCHOOL DISTRICT OF THE CHATHAMS
Authorization for administration of medications during school hours
Valid for the school year _____ to _____

To be completed by the **Parent /Guardian**:

Child's Name_____ Date of Birth_____

Physician's Name_____ Physician's phone_____
Physician's Address_____

As the parent/guardian, I request the administration of the medication below, as ordered by my child'd physician

Parent/Guardian Signature_____ Date_____

To be completed by the **Prescribing Physician or Advance Practice Nurse**
Please make a copy of this form for your records in accordance with FERPA and HIPPA laws

Diagnosis:_____
Medication_____Dose:_____ Form_____
Route_____
If medication is to be given daily, at what time?_____
If medication is PRN describe indications:_____
List significant side effects:_____
Length of time this treatment is recommended:_____
This pupil is physically fit to attend school and is free of contagious disease.
This pupil would not be able to attend school if the medication is not administered during school hours.

Physician Signature_____Date_____Stamp_____