CHARTIERS VALLEY
SCHOOL DISTRICT | Inspiring excellence.

PHYSICIAN'S REQUEST FOR ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

Dear Doctor:

The parent/guardian of _____has requested that we administer the prescribed medication _____to the student during the school day.

If it is essential that the student receive the medication during school hours, please complete the following information.

Diagnosis _____
Name of Medication _____
Dosage _____
Time Schedule for Administration _____
Number of Days for Administration _____
Side Effects or Curtailment of Activity _____
(Sports, Recess, etc.)

List any other medication prescribed and indicate whether or not the medication interacts harmfully with the prescribed medication.
Explain _____
_____
_____
_____

Date _____

_____
Physician's Signature

_____
Physician's Phone Number

_____
School Nurse's Signature

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PARENTAL MEDICINE PERMISSION FORM
(This permission form must be accompanied by written orders from the attending physician)

Please complete the following information and enclose with each medication you send to school to be taken during school hours.

STUDENT NAME_____HOMEROOM_____

NAME OF MEDICINE_____

PRESCRIBED BY PHYSICIAN? Yes _____ _____
(Name of Physician)

INCLUDE THE DOCTOR'S WRITTEN ORDERS WITH YOUR PERMISSION FORM.

PRESCRIPTION #_____
NAME OF PHARMACY _____
DOSAGE _____ at _____for _____days.
(Times) (Number)

I WILL TAKE FULL RESPONSIBILITY FOR THE PRESCRIBED MEDICATION, WHICH IS TO BE GIVEN DURING SCHOOL HOURS.

_____
(Signature- Parent/Guardian)

_____
(Date)

_____
(Phone-Home)

_____
(Phone-Work)

The medicine container must be properly labeled with the student's name, homeroom, name of the medication and the time and dosage to be given.

Medications that do not comply with these guidelines will not be given by school personnel and will be returned to the parent or guardian.