2025-2026
Chatfield School
Medication Authorization Information

Student: _____ **Date of Birth:** _____

Grade: _____ **Homeroom Teacher:** _____

Instructions: (one form per medication)

Name of Medication: _____
(Medication must be in original container and medicine will be dispensed as written. If a change is made, it must include a doctor's signature when dropped off)

Over the counter medication must be approved in writing by a doctor and prescription included with this form.

Form of medication/treatment:

☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Cream/Lotion

☐ Other_____

Begin Date: _____ **End Date:** _____

Instructions (Schedule and Dose to be given at School): _____

_____

_____

Possible reactions and/or side effects:

☐ None anticipated

☐ Yes, please describe: _____

_____

Special Storage Requirements: ☐ None ☐ Refrigerate

Other: _____

Date: _____ **Parent Signature:** _____

***Must have a prescription to attach to this form.**