23-24
Chatfield School
Medication Authorization Information

Student: _____Date of Birth: _____

Grade: _____ Homeroom Teacher: _____

All medications must be provided in the original packaging this includes over the counter medication.

Instructions: (one form per medication)

Name of Medication: _____

Prescribing Physician (if applicable):_____Phone #_____

Form of medication/treatment:

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

(Please indicate the # of tablet/capsules or uses in container_____)

☐ **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: _____

I hereby give permission for authorized school personnel to supervise the dispensing and/or administration of the medication listed for the above named child. I also agree to allow information to be exchanged with my child's physician if/when deemed appropriate.

Date: _____ Parent Signature: _____