

2015-2016
Chatfield School
Medication Authorization Information

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

Grade: _____ **Homeroom Teacher:** _____

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 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:** _____