CHATHAM
COUNTY SCHOOLS

Administration of Medication During School Hours

Name of Student: _____ School: _____ Date: _____

1.)Medication:	2.)Medication:
_____	_____
Dosage _____	Dosage _____
Purpose	Purpose _____
_____	Time of administration _____
Time of administration	Termination of administration _____
Termination of administration _____	Form of Medication: (circle below)
Form of Medication: (circle below)	tablet capsule
tablet capsule	liquid ointment/drops
number of pills/tablets sent to school	inhalation
liquid ointment/drops	**(My child knows how to use the inhaler and self carries) Yes No**
inhalation	

To be completed by licensed health care provider:
Physician's Signature _____ Date _____

_____
Physician's phone number

To be completed by Parent or Guardian:
I give my permission for my child, named above, to receive medication during school hours. A licensed physician or nurse practitioner has prescribed this medication.
I assume full responsibility for informing the principal of any changes in my child's health or medication. I release the School Board, their agents and employees from any and all liability that may result from my child taking the prescribed medication. I understand that I am responsible for furnishing this medication within a container properly labeled by a pharmacist with identifying information (e.g., name of child, medication dispensed, dosage prescribed and time to be given).

_____ _____
Signature of Parent or Guardian Date

_____
Parent or Guardian Phone Number

To be completed by School:
Name, Title and Initials of Person(s) to Administer Medication _____

_____

Reviewed and Approved by: _____

_____ _____
Signature of School Nurse Date