DISPENSING OF MEDICATION DURING SCHOOL HOURS
CHATHAM COUNTY SCHOOLS

School: _____ Teacher: _____

To be completed by physician:

Name of Student:_____ DOB_____

Medication: _____ Dosage: _____

Form of Medication to be given is circled below:

Tablet Ointment Capsule Inhalation Liquid

Other (Specify): _____

Purpose of Medication: _____

Time to be administered: _____ a.m. _____ p.m.

Possible side effects: _____

Contraindications: _____

Termination Date for Administering: _____

_____ _____
Physician's Signature Date

_____
Physician's Phone Number

****

To be completed by the Parent or Guardian:

I hereby give my permission for my child (named above) to receive medication during school hours. This medication has been prescribed by a licensed physician. I assume full responsibility for informing the principal of any changes in my child's health or medication. I hereby release the School Board and their agents and employees from any and all liability that may result from my child taking the prescribed medication. I will furnish this medication within a container properly labeled by a pharmacist with identifying information (e.g. name of child, medication dispensed, dosage prescribed, and the 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:

_____

_____

Approved by: _____ _____
Signature of Principal Date

Reviewed by: _____ _____
Signature of School Nurse Date