PRESCRIPTION MEDICATION
PHYSICIAN'S ORDER AND PARENTAL CONSENT

The medication policy of the Chester County School System states that medications be administered only when the student's health requires that they be given during school hours. Medications administered at school must be in original container with pharmacy label attached and administered under the supervision of the school nurse, school administrator, or his/her designee. Written authorization from the student's parent/guardian and physician is required, and is for the current school year only.

STUDENT: ______________________________ **DATE:** __________

PHYSICIAN'S SECTION

The above named student is to receive:
Medication Name: ______________________________

Dosage and Route of Medication: ______________________________

Time(s) medication is to be taken at school: ______________________________
Diagnosis: ______________________________
Date of termination of this medication: ______________________________
Possible side effects and/or other special instructions: ______________________________

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Date: __________ Physician's Signature: ______________________________

(*Please print the following three items*)
Physician's Name: ______________________________

Address: ______________________________

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Phone Number: ______________________________

The undersigned assumes full responsibility for any side effects or complications his/her child may have as a result of taking this medication, and is responsible for informing the school of any changes in treatment. Physician's orders must accompany any medication changes.
I hereby give my permission for my child to take the above listed medication.

Parent/Guardian Signature: ______________________________ Date: __________

Home Phone: ____________________ Work Phone: ____________________

Emergency Phone: ______________________________