



PRESCRIPTION MEDICATION CONSENT FORM

CHILTON PUBLIC SCHOOLS



PHYSICIAN'S ORDER FOR MEDICATION

Student's Name: _____ Date: _____ Grade: _____

Teacher: _____ Age: _____ Date of birth: _____

Physician Name: _____ Phone #: _____ Fax #: _____

FOR PHYSICIAN TO FILL IN: In order for the school personnel to administer the medication regime you have prescribed, please complete the following section of this form.
Substances which are not FDA approved will require a physician's order.

Name of Medication	Dosage	Time of Day to Take	Term: Long or Short

Name of Medication and side effects to watch for: _____

Please indicate if the medication above is PRN medication _____
Conditions under which PRN medication should be given are _____

Physician's Signature: _____ Date: _____

PARENT/GUARDIAN: (Please fill out the top portion of the form, after your child's physician has completed the middle section you should sign it and return this to the school office.)

I hereby give my permission to school personnel designated by the school principal to give medication to my child according to the written instructions of the physician as shown above.

I also hereby agree to give my permission to the school principal/designee to contact the child's physician.

I further agree to hold the Chilton School District and all employees harmless in any and all claims arising from the administration of this medication at school, and/or on field trips.

I agree to notify the school in writing at the termination of this request or when any change in the above is necessary.

PLEASE NOTE

Any medication brought to school should be in a duplicate labeled pharmacy container.

A parent or legal guardian is required to deliver the medication directly to the school nurse or designated staff member.

Parent/Guardian Signature _____ Phone # _____ Date _____