

**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'S NAME: \_\_\_\_\_

DATE \_\_\_\_\_

**PHYSICIAN'S SECTION**

The above named student is to receive:

Medication Name: \_\_\_\_\_

Dosage & 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: \_\_\_\_\_

\_\_\_\_\_

Date: \_\_\_\_\_ Physician Signature: \_\_\_\_\_

(Please print)

Physician Name \_\_\_\_\_

Address \_\_\_\_\_

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 medication.

Parent / Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

Emergency phone \_\_\_\_\_