Chariho School Department
Authorization for Medications to be Taken During School Hours
(Original Pharmacy-labeled containers only)

NAME ______________________________ DOB ________________ GENDER: M / F

SCHOOL ______________________________ GRADE/TEAM ____________________

ALLERGIES: ____

____

To be completed by the Parent:

I hereby consent that the School Nurse Teacher may give my child the medication ordered below by the prescribing physician and release the CHARIHO Regional School District and its employees of any responsibility in case of an accident. I understand that I must personally deliver the medication to school and unless I repossess any unused medication within seven (7) days following the last day on which it is administered, it will be destroyed.

Parent/Guardian ______________________________ Date ______________________

Phone: Home / Cell ______________________ Emergency #______________________

____

To be completed by the Physician:

Diagnosis for which medication is given: ______________________________________

Name of Medication: ______________________________ Dosage: __________________

Route: ______________ Frequency: ________________ Time(s): ____________________

If there is any reason why the medication must be given at a specific time and not the present standard flexibility of ½ hour please specify. ______________________________________

If medication is to be given "when needed" describe indications: ______________________

____

How soon can it be repeated (if applicable)? ______________________________________

List significant side effects: ____

Start Date ____________________________ End Date ____________________________

Physician Signature: ____________________________ Date: ______________________

Physician Name: ______________________________ Phone Number: _________________

School Nurse Teacher: __________________________ Date: ______________________