Chandler Unified School District

CONSENT FOR GIVING PRESCRIPTION AND NON-PRESCRIPTION MEDICATION AT SCHOOL

Please check here if **NON**-prescription: ☐

Student Name: _____ Birthdate: _____

For prescription medication, the physician must complete the information required below. Medication must be delivered to school in the original container with the label intact, and is to be given in the following manner:

Name of Medication: _____

Strength of Medication: _____

Amount to be Given: _____

Time of Administration at School: _____

Route of Administration (by mouth, etc.): _____

Comments and/or Instructions: _____

Reason for Medication: _____

Date Medication is to be Discontinued: _____

Physician's Name: _____ Phone No.: _____
(please print)

_____ _____
Physician's Signature Date

I hereby request and give consent for the person designated by the principal to administer the medication indicated above. I understand my child's medication is to be presented to a school representative by an adult. I will assume full responsibility for the supply, appropriate transportation and maintenance of prescription medication. I hereby give permission for the exchange of information regarding my child's medication.

_____ _____
Parent/Guardian Signature Date

_____ _____
Teacher Room Number

_____ _____
Parent/Guardian Home Phone # Parent/Guardian Work Phone #

If any changes in medication or dosage occur, the school must be notified immediately, and a new form must be completed.