Chagrin Falls Exempted Village Schools
Request for the Administration of Medication by School Personnel

TO BE COMPLETED BY PHYSICIAN

The student indicated above is under my care and should receive the medication indicated below. It is not possible to arrange for this medication to be taken at home under the supervision of a parent, and therefore, must be taken during school hours.

Student

Homeroom Teacher

Date of Birth

Address:

City/State/Zip Code:

Name of Medication:	
Dosage:	
Number of Times or Interval Medication is to be given:	
Date to Begin Administration:	
Date to End Administration:	
Adverse reactions that should be reported to Physician:	
Special instructions for the administration of medication:	

Physician's Printed Name **Phone**

Physician Signature **Date** **Fax**

TO BE COMPLETED BY PARENT/GUARDIAN

Parent Contact Information

Name	Relationship	Phone	Work Phone	Cell Phone
	Mother / Guardian			
	Father / Guardian			

The parent/guardian(s) agree to submit a revised statement by the physician who prescribed the drug to the person designated to administer medication if any of the information provided by the person licensed to prescribe medication as described above changes.

Parent/Guardian Signature **Date**

Copies: School Nurse
Pupil Services
Parent

11/05