

<b>Chagrin Falls Exempted Village Schools</b>				
<b>Request for the Administration of Medication by School Personnel</b>				
<p align="center"><b>TO BE COMPLETED BY PHYSICIAN</b></p> <p>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.</p>		<b>Student</b>		
		<b>Homeroom Teacher</b>		
		<b>Date of Birth</b>		
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	
<b>TO BE COMPLETED BY PARENT/GUARDIAN</b>				
<b>Parent Contact Information</b>				
<b>Name</b>	<b>Relationship</b>	<b>Phone</b>	<b>Work Phone</b>	<b>Cell Phone</b>
	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