Chatfield Public School, I.S.D. #227 *Please fax to _____888-518-0702(Elementary)
Chatfield, MN _____888-518-0701(High School)

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

For school year _____or_____(field trip/dates/other)

Student's Name_____ Date of Birth_____ Grade____
Medication Allergies_____ Weight (in pounds) _____

___ I hereby request that the medication(s) listed below be **administered by designated school personnel** (or other responsible adult, following the school district's medication policy) to the above named student during school hours and on school field trips.

___I hereby request that the medication(s) listed below be **carried and self-administered by the above named student** during school hours and on school field trips. I understand that the student is entirely responsible for the use of this medication and that use of this medication will NOT be monitored by school staff.

Medication	Dose	Frequency	Time(s)	Duration	Reason for use

Additional recommendations/unusual side effects: _____
Other medications the student is currently taking:_____

Physician Authorization

A physician's signature is required for the following:

- **Any prescription medication that is to be administered by school personnel or carried and self-administered by the student.**
- **Any nonprescription (over-the-counter) medication that the student is to carry and self-administer (with the exception of pain relievers, which may be carried by students in grades 9-12 and taken as directed on the medication label if parent/guardian authorization has been received)**
- **Any nonprescription (over-the-counter) medication for which the requested dose exceeds the dose recommended on the medication label.**
- **Aspirin or any medication that contains aspirin**

Physician Signature_____ Printed name: _____
Clinic:_____ Phone:_____ Fax:_____

Parent/Guardian Authorization

1. I release all school personnel and I.S.D. #227 from any and all liability in the event that any adverse reaction results from the use or administration of the above medication(s).
2. I will immediately notify the school of any change in medication, or change in the dose, frequency, time, or duration of administration.
3. I give permission for the school nurse to consult with the prescribing physician or my child's primary health care provider concerning any questions that arise with regard to the listed prescription medication(s) or medical condition for which medication has been prescribed

I have reviewed and understand the Chatfield Public Schools' Medication Policy
Parent/guardian signature(s)_____ Date:_____
Daytime phone_____ Evening phone:_____ Cell phone_____