

CHESTER TOWNSHIP SCHOOL DISTRICT
Chester, New Jersey 07930

MEDICATION ADMINISTRATION REQUEST

Student's Name _____ Grade/Homeroom _____

Home Phone Number _____

TO BE FILLED OUT BY PHYSICIAN:

Please administer the following medication to the above named student as prescribed below:

Medication/Dose _____

Reason for Medication _____

Time to be Administered _____

To be given from (date) _____ Stop Date _____

Side Effects to be reported _____

Medication for non-life threatening conditions will NOT be administered on field trips unless medically required by a physician.

On field trips, medication is _____ is not _____ required.

On half days, medication is _____ is not _____ required.

Physician's Stamp:

Physician's Signature: _____

TO BE SIGNED BY PARENT/GUARDIAN:

I give my permission for the above medication to be administered to my child at school. I realize that any changes or modifications of this order will require a written authorization from this physician.

Parent/Guardian's Signature _____ Date _____