



Chapel Hill
ACADEMY

School Year: _____

**CONSENT FOR ADMINISTRATION OF MEDICATION OR PHYSICIAN
ORDERED TREATMENT DURING THE SCHOOL DAY**

Parents of students requesting that medication or a medical treatment be administered during school hours by school staff are required to provide for the school: **(1)** the physician's order, **(2)** a parental release and **(3)** medication in the prescribed bottles.

STUDENT NAME _____

GRADE _____ **TEACHER** _____

**PHYSICIAN'S ORDER FOR ADMINISTRATION OF MEDICATION BY
SCHOOL PERSONNEL**

I have prescribed the following medication or treatment for this child and request school personnel administer the dosage/treatment given during school hours.

Medication or Treatment _____

Dosage and time of administration _____

Purpose or condition for which prescribed _____

Remarks _____

Signature of Physician _____ Date _____

*Your physician may fax this information to our office at 952-556- xxxx.

PARENTAL RELEASE FOR ADMINISTRATION OF MEDICATION

I request that the above medication/treatment be administered to my child as prescribed by the physician. I understand I must provide medication in the original bottle, properly labeled by the pharmacy with the student's name, date, dosage, time and directions for administration. I release school personnel from any liability in relation to the administration of this medication or treatment at school.

Parent/Guardian Signature _____ **Date** _____