

**PRESCRIPTION MEDICATION AUTHORIZATION FORM
CHAPEL HILL CHRISTIAN SCHOOLS**

Dear Parent:

CHCS#111

In order to have a prescription drug administered to your child, have your physician complete and sign this form. You must then read and sign the form and return it to the Principal's office.

THIS AUTHORIZATION MUST BE RENEWED AT LEAST EVERY SCHOOL YEAR.

TO BE COMPLETED BY PHYSICIAN (must be fully completed)

NAME OF PATIENT-

STUDENT _____ GRADE _____

ADDRESS _____

The following medications may be administered by school board authorized personnel during school hours:

<u>DRUG</u>	<u>DOSAGE</u>	<u>FREQUENCY & TIME OF DAY</u>
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_____	_____	_____
_____	_____	_____

DATE TO BEGIN _____ DATE TO
STOP _____

Special instructions for administration (including sterile conditions & storage). _____

Reactions/Side Effects To Be Reported To Physician

DATE _____ PHYSICIAN'S

SIGNATURE _____

PHYSICIAN'S NAME (typed or

printed) _____

PHYSICIAN'S ADDRESS

TELEPHONE NUMBER _____ FAX NUMBER _____

NOTE: *The prescription **must** be received in its **original container** in order to be dispensed by school personnel.*

TO BE COMPLETED BY PARENTS/GUARDIAN:

I hereby request that school board designated persons administer the prescription medications indicated above in the Physician's Statement to my son/daughter during school hours. I agree to submit to the school a new form, signed by myself and the physician, if there is a change in the physician or the medication.

By signing this form, I hereby agree on behalf of myself and my child that no person who has been authorized by the Board's policy to administer a drug, and who has the most recent copy of this form prior to administering the drug will be liable in civil damages for administering or failing to administer the drug unless such person acts in a manner that constitutes gross negligence or wanton or reckless misconduct.

PARENT/GUARDIAN SIGNATURE _____

DATE _____