Chestnut Ridge School District
3281 Valley Rd.
Fishertown PA, 15539
(814) 839-4195

Consent Form for Medications

We request that authorized school personnel administer this medication to _____ (student) _____(grade) according to the directions from our attending physician. As parent/guardian of the above named student, we hereby release the Chestnut Ridge School District and its employees from all liability for damages that our child may suffer as a result of this request.

_____ _____
Date Signature of parent/guardian

****ALL MEDICATION MUST BE BROUGHT TO THE HEALTH ROOM BY A RESPONSIBLE ADULT IN THE ORIGINAL BOTTLE .**

TO BE COMPLETED BY PHYSICIAN

It is essential that the above named student receive the following medication(s) during school hours:

Name of medication _____

Dose_____ Administration time_____ Termination date_____

Purpose of medication _____

Possible side effects, contraindications, and/or restrictions of school activities:
_____
_____

Other medications that student is taking outside of school hours
_____

Is student capable of self-administration? _____
Should student carry medicine/inhaler with him/her?_____

_____ _____
Date Physician signature

_____ _____
Physician phone and fax number Physician printed name