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_____