CHESTER COUNTY INTERMEDIATE UNIT
Child and Career Development Center
1525 E. Lincoln Highway, Coatesville, PA
Phone: 610-383-7400 ◆ Fax: 610-383-0992

PERMISSION TO DISPENSE MEDICATION IN SCHOOL
(Please complete this form and return to the school nurse)

Student's Name: _____ **Birth date**:_____ **Teacher**:_____

Dear Parent/ Guardian,
In order to give your child the medication as requested and supplied by you, the following **must** be provided:

- ☐ A written order from the doctor that includes (***MEDICATION NAME, DOSE, TIME TO BE GIVEN AND DOCTOR'S SIGNATURE***). The physician may fax the medication order to the school.
- ☐ This permission form completed and signed by parent/guardian
- ☐ Medication in its original prescription bottle from the pharmacy

MEDICATIONS CANNOT BE DISPENSED IN SCHOOL WITHOUT ALL THE ABOVE ITEMS.

You have my permission to give _____ medication in school.
(Student's Name)

Name of Medication	**Dose**	**Time to be given**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Reason for taking medication(s):_____

Medication was prescribed by: _____
(Doctor's Name)

_____ _____
(**PARENT/ GUARDIAN SIGNATURE)** **(DATE)**