CHESTER COUNTY INTERMEDIATE UNIT
Chester County Learning Center
1635 E. Lincoln Highway, Coatesville, PA
Phone: 610-384-6030 Fax: 610-384-6038

PERMISSION TO DISPENSE MEDICATION IN SCHOOL

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

ON EARLY DISMISSAL DAYS, medications administered after 1:30 will not be given unless indicated in the box below (please initial on line below)

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)

EARLY DISMISSAL DAYS: _____ give medication at school at 1pm.

_____ medication will be given at home
(parent initials)

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