Phone: (530) 547-9726
Fax: (530) 547-9734
catherinet@chrysalischarter.org

Address:
P.O. Box 709
Palo Cedro, CA 96073

CHRYSALIS CHARTER SCHOOL MEDICATION AUTHORIZATION FORM

This form must be completed fully in order for schools to administer the required medication. A new medication authorization form must be completed at the beginning of each school year, for each medication and each time there is a change in dosage or time of administration on a medication.

- Prescription medication must be in a container labeled by the pharmacist or prescriber.
- Non-prescription medication must be in the original container with the label intact.

To be completed by parent or guardian:

Name of Student____Date of Birth___________Grade______

I request that my child, named above, be assisted in taking the prescribed medication listed below at school by authorized persons. I will comply with the school's policies and procedures. I agree to, and do hereby hold Shasta County Office of Education, and Chrysalis Charter School, and their employees harmless from any and all claims, demands, causes of action, liability or loss of any sort because of, or arising out of, the acts or omissions of the County and Chrysalis Charter School and their employees with respect to this medication.

Name of medication to be administered at school:

Reason for the Medication:

______________________________ ______________ ______________

Parent Signature **Date** **Phone Number**

To be completed by Physician only:

Medication Name:__________________________________Dose:_____________Route_____________

Time/times to be taken:__________________________________Frequency:__________________

Reason for Medication:____

Possible side effects:____

The student for whom this medication is prescribed is under my care.

______________________________ ______________________________ ______________ __________

Print Name of Licensed Physician Signature of Licensed Physician Phone Date