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

Chrysalis
CHARTER SCHOOL

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

School Medication Authorization Form

If your child will need medication administered at school including asthma inhalers, this form must be filled out by the parent and doctor. The medication must be brought to school in its original container. Bring the medication with this filled out form to the office. Thank you.

To be completed by parent before giving this form to your doctor:

Name of Child _____ Date of Birth _____

I request that my child, _____, 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 School and their employees with respect to this medication.

Name of medication requested to be given at school:

Reason for the Medication:

_____ _____ _____
Parent Signature Date Home Phone

To be completed by Physician only:

Name of medication/strength _____ Dose form: liquid tablet

Dosage _____ Time/times to be taken _____

_____

Reason for medication: _____

Possible side effects: _____

Comments: _____

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

_____ _____ _____ _____
Print Name of Licensed Physician Signature of Licensed Physician Phone Date