Slate Valley Union School District

School: OVS _____ BVS _____ CES _____ FHGS _____ FHUMHS _____

Prescription Medication Permission Form

THIS FORM NEEDS TO BE COMPLETED **ONLY** IF YOUR CHILD IS **TAKING A PRESCRIPTION** THAT NEEDS TO BE GIVEN WHILE AT SCHOOL-THIS **INCLUDES INSULIN, INHALERS, SEIZURE MEDICATION, GLUCAGON AND EPI-PENS, ETC.**

Date:_____ Name: _____ DOB: _____ Grade: ____

I hereby give my permission to **Dr.** _____at_____ and the pharmacy listed below to release information to the school nurse at the Slate Valley Unified Union School District concerning medication(s) prescribed for my child listed above and authorize faxing the information to the School Nurse at the number on the bottom of this form.

I hereby give my permission for my above named child to take the medication as prescribed at school and release the school of any liability as a result of any injury resulting from the administration, self or otherwise, of the below medication. My child understands that this medication is for their sole use and will never be shared with anyone else.

Parent/Guardian Signature:_____

Medication:_____Strength:_____Dose:_____

Directions for use:_____ Duration: _____
Number of days or "school year"

Diagnosis:_____ Instructions for Managing Life Threatening Allergy(ies): _____

_____

**For Epipens and Inhalers: This student is capable and has been instructed on self-administration, possible side effects and when and how to access emergency services.

***Physician/Provider Signature:**_____

Name of Pharmacy/Location: _____

No medication will be given at school until the school nurse receives this completed form with the prescribed medication in the **pharmacy labeled container** (ask pharmacy for second labeled bottle to provide school with medication). All medication will be routinely kept in the nurses' office with the exception of approved self-carried life sustaining/emergency medications.

Signature of School Nurse: _____Date:_____

PLEASE FAX BACK TO: _____