MEDICATION PERMISSION AT SCHOOL

Student Name_____Birthdate_____
Grade_____**Physician Name**_____**Office Phone**_____
Parent/Guardian Name_____ Daytime Phone_____

Name of Medication_____Dosage_____

Description of Medication (color, pills, liquid, etc.)_____
Date(s) to be given_____Times to be given_____
Strength (mg) to be given_____Number (pills, tsp, units, etc.)_____
Illness or condition _____

If given as needed, how much time between doses?_____

Special Instructions_____

Refrigeration needed?_____ Return medicine home daily with student?____

Will student be self-medicating and keeping it with them? _____ If so a **release form** must be signed by both parent and student and attached.

***Please note that all medication must come in original bottle with appropriate name, medication, dosage, frequency, date, and physician name clearly visible.*

I request and authorize Valentine Community Schools to supervise the medication routine described for the above named student. I further authorize the school to contact my student's physician if deemed necessary. <u>I accept ultimate responsibility for monitoring the effects of this medication.</u>

Parent Signature_____ Date_____