VICTOR CENTRAL SCHOOL DISTRICT
PERMISSON FOR ADMINISTRATION OF MEDICATION

In the event it is necessary for the welfare of your child that any medication be administered during school hours, you must comply with the following or delays may result in your child's receipt of medicine:

1. Have your child's physician complete the Physician's Statement section of this form In its entirety;
2. Complete the Parent Statement section of this form in its entirety; and
3. Provide a current wallet size photo of the student for safe identification purposes.

PHYSICIAN'S STATEMENT

____

Child's name: ____

Medication: ____

Dosage: ____

Time: ____

Duration: ____

Possible side effects: ____

Reason for medicine: ____

If the morning dose usually given at home has been forgotten, the nurse may administer it at school after verbal or written notification from the parent.

Drug: ____________________________________ AM Dose:__________________
Modify the regular noon-time dose as follows: ____
Date:______________________

_______________________________________ _______________________

Physician's signature **Date**

PARENT STATEMENT

By completing and signing this form, I give permission for my child,_________________________ to take this medication as prescribed above. I understand the determination of whether my child is self-directed or not self-directed is the ultimate responsibility of the school nurse/physician overseeing the medication in a school setting. I further understand that any assessment may change based on a student's demonstration of responsibility. To help in that assessment, I assess my child to be:

_______________**Non-Self Directed** (must be reminded & supervised in storage & administration of medication)

_____________________________________ ______________________

Parent Signature **Date**