THE RIVER VALLEY LOCAL SCHOOL DISTRICT
PHYSICIAN'S PERMISSION FOR THE ADMINSTRATION OF MEDICATION

The River Valley Local Schools do not wish to dispense medication to students during the school day unless it is absolutely necessary. If the medication must be administered during the school day, it will be done within Board of Education Policy JHCD, of which this form is a part.

Top Portion of this form is to be completed by child's Physician

Name of Student _____

Address of Student _____

School Attended by the Student: _____

I certify that the above named student is under my care and should receive medication as follows:

Name of Drug: _____

Dosage: _____

Route: _____

Said student should receive above identified drug at the following time(s).

_____ _____ _____ _____

Beginning Date: _____ Expiration Date of this Request: _____

Specific instructions for administration, including storage and sterile requirement(s):

_____

Possible reactions which should be reported to the physician:

_____

Date: _____ Physician Signature: _____

Address: _____ Phone: _____

THE RIVER VALLEY LOCAL SCHOOL DISTRICT
PARENT MEDICATION ASSISTANCE REQUEST

Bottom Portion of this form is to be completed by child's Parent/Guardian

My child: _____

is taking (Name of Medication): _____

Prescribed by: _____
(Name of Physician)

_____
(Address of Physician)

Dosage He/She takes: _____ at _____
(Specified time or times)

for _____ days beginning _____
(Period of time medication will be needed)

I understand that a school district designee will assist in dispensing the medication within the Board of Education Policy. I also understand that it is my responsibility to inform the school if any of the above information changes.

Signature of Parent/Guardian) _____ Date _____