RIVER VALLY LOCAL SCHOOL DISTRICT

PHYSICIAN'S PERMISSION FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

Top portion of this form must be completed by the child's Physician.

Name of student: _____

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

Name of drug: _____

Diagnosis: _____

Dosage: _____

Route: _____

Said student should receive above identified drug and above dosage at the following time(s):

_____ _____ _____

Beginning Date: _____ Expiration Date of This Request: _____

Specific instructions for administration, including storage and sterile requirements:

_____

_____

Possible reactions: _____

_____

Date: _____ Physician Signature: _____

Phone: _____ Fax: _____

PARENT MEDICATION ASSISTANCE REQUEST

Bottom portion of this form must be completed by the child's parent/guardian.

My child's name: _____

Name of medication he/she takes: _____

Prescribed by: _____

1st Dosage: _____ Specific Time: _____

2nd Dosage (if applicable): _____ Specific Time: _____

I want my child to begin taking his/her dosage(s) daily at school beginning _____.

Other Information: _____

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

Parent/Guardian Signature: _____ Date: _____