

SCHUYLKILL VALLEY SCHOOL DISTRICT

Health Services

Medication Permission Form

Dear Parent/Guardian:

In order to comply with your request that we administer medication to your child during school hours and to prevent a possible error in giving medications, this permission and information form must be completed and returned to the school nurse. This applies to both prescription medication and over the counter medications. The medication must be in the original pharmaceutical container and must be properly labeled. Any changes in type or dosage of medication must be reported to the nurse. * Do not send improperly labeled bottles to school. Information on the label must include what is listed below.

Elementary School

Mrs. L. Schaeffer, BSN RN, CSN

lschaeffer@schuylkillvalley.org

Ph: 610-916-5728

Fax: 610-916-5048

Middle School

Mrs. C.Sherman, LPN

csherman@schuylkillvalley.org

Ph: 610-916-5587

Fax: 610-926-3321

High School

Mrs. N. Koller, BSN, RN, CSN

nkoller@schuylkillvalley.org

Ph: 610-916-5486

Fax: 610-926-8341

I give my permission for the school nurse, or her designee, to give the following medication to my child during school hours:

Name of student _____ Date of birth: _____

Name of medication _____

Diagnosis _____

Dosage (amount to be given) _____

Time to be administered _____

Physician's signature _____ Date _____

Parent's signature _____ Date: _____