VALLEY CHRISTIAN SCHOOLS

Medication Request/Consent Form

Medications are to be administered at home whenever possible. If it is necessary for a student to receive medications at school, all appropriate portions of this form must be completed before medication can be given at school.

One form for EACH medication is required.

Name of Student:____School: _____________________________Grade: _________

Address:____Phone:________________________Birthdate: ____________

Physician Name: ____ Phone: ________________________

MEDICATION/PROCEDURE:

Name of Medication or Procedure: ________________________________ Reason for medication/procedure (diagnosis): ___________

RX# (if applicable) __________________________________How Given: ____

Time to be given at school: ___________ **Dose** at School:___________ **Dates** to be given: From: _____________To:____________

If medication is to be given on an as needed basis (PRN), state conditions under which medication is to be given: _________________

____

Precautions/Unfavorable Reactions: ____

INHALERS AND EPI PENS

Elementary and Jr. High Students:

- ASTHMA INHALER:

This student is capable of self-administration and may carry inhaler and self-administer at school. D Yes D No
All inhalers must have **Student Name** on the medication. **Allergy to:** ____

- EPI PENS: Please provide two Epi pens:

EPI Pens will be administered by school personnel. Please provide in original packaging with **Student Name** on the Pen.

HS Students:

- ASTHMA INHALERS AND EPI PENS: This student is capable of self-administration and may carry inhaler or EPI pen and self-administer in school. D Yes D No
- Please provide two Epi pens: one for on person and one for designated medication storage area at school.
- All inhalers and EPI Pens must be in original packaging with **Student Name** on the medication.

PARENT/GUARDIAN CONSENT: (complete for all Medication/Procedures at school)

- I request and authorize that school personnel administer this medication at school.
- I will supply medication in its original, updated, properly labeled container. (Request extra bottle from pharmacist.)
- This order is in effect for this school year unless otherwise indicated.
- I will obtain a new physician's order and notify the school in writing for any changes.
- I authorize school personnel to exchange information verbally or in writing with my child's physician regarding this medication or the conditions for which it is prescribed.
- I further understand that all medication is to be transported to and from school by parent/guardian.
- I understand that non-medically trained school personnel will give medication
- I agree to hold the School District, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.
- My signature indicates that I have fully read and understand the above information.

_______________________________ _______________/_______________ _______________________

Signature of Parent/Legal Guardian | Telephone Home | Business | Date