Nodaway Valley School Medication Form

TO BE COMPLETED BY PARENT OR GUARDIAN

I request that my child, _____, date of birth of _____, be assisted in taking this medication at school. I will comply with the school's policy and procedures. I agree to, and do hereby hold the school and its employees harmless from any and all claims, demands, causes of action, liability or loss of any sort because of, or arising out of, the acts or omissions of the school or its employees with respect to this medication. I also give the NV nurse permission to contact the Prescribing Doctor with any questions or concerns. A separate form must be filled out for each medication. This form is effective for a single school year. Thank you for your cooperation.

_____	_____	_____	_____
Parent Printed Name	Parent Signature	Date	Phone #

Name of Medication/Strength: _____

Purpose of Medication: _____

Dosage: _____

How Often: (ex: every 2 hours) _____

Time to be given at school: _____

Dose Form: (ex: tablet or liquid) _____

Give medication on late start days? YES____; if so what time? _____ NO _____

Give medication on early out days? YES _____; if so what time?_____ NO _____

Duration: _____ (start date) through _____ (end date)

Preferred Method for Refills (circle one): SEND WITH STUDENT THROUGH PARENT

Preferred Method to Communicate Refills (circle one): EMAIL TELEPHONE CALL

Comments: _____

Students are not permitted to carry medications at school or at school sponsored trips or events, except for prescribed inhalers or Epinephrine Pens with proper permission form.