VALOR EDUCATION

Request for Long-term Administration of Medication at School - More than 15 Days

Prescriber Authorization

Student Name: ____ Date of Birth: _____/_____/_____

Sex: M ___ F __ Grade:_______________ Teacher/Homeroom: ____________________________

Medication Name: ____ Dose: __________________

Route: _____________ Frequency: PRN ___ Scheduled ___

Time(s) to be administered during school hours: ____

Reason medication being given: ____

Medication shall be administered from: _____/_____/_____ to: _____/_____/_____

Special requirements for administration or storage: _______________________________________

Known food or drug allergies: Yes ___ No ___

If Yes, please explain: ____

Prescriber's Printed Name: _____________________________ Phone: _______________________

Facility Name: ____

Prescriber's Signature: __________________________________ Date:_______________________

Parent/Guardian Authorization

I request that school health staff administer the medication as described above. I consent to medication administration for my child named above and agree to review and provide any special instructions for the administration of the child's medication and share that information with school health staff.

Parent/Guardian Signature: _______________________________________ Date: ____/____/____

Phone Number: __________________________

Faculty Review

Medication was received from: _____________________________________ Date: ____/____/____

Medication was received by: ____ Date: ____/____/____

Initial Count or Measurement: ____

Witness Signature: ____ Date: ____/____/____