VALOR EDUCATION

Request for Short-term Administration of Medication at School - 15 Days or Less

Medication Information

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

Sex: M ◯ F ◉ Grade:_____ Teacher/Homeroom: _____

Medication Name: _____ Check one: Rx ◯ OTC ◉

Dose: _____ Route: _____ Time(s) of day to administer:_____

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: _____

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. I understand that after 15 calendar days I may retrieve the remaining medication or it will be discarded by school health staff. (See date of expiration below.) *If administration of the medication is needed beyond 15 calendar days, I understand that a prescriber's authorization will be required.*

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: ____/____/____

Form expiration date: _____/_____/_____