VAN ALSTYNE INDEPENDENT SCHOOL DISTRICT

MEDICATION CONSENT

STUDENT INFORMATION

Student's Name _____ Date of Birth _____ Grade/Teacher _____

Name of Medication _____ Dose _____

Reason for Taking _____ Time of Day to be given _____

Special Instructions:

_____

_____

Does medication require refrigeration? Yes □ No □

PARENT AUTHORIZATION

I certify the above information is correct. I, the undersigned, authorize officials of this school to contact the person named as physician for any medical emergency. If physician is not available, I authorize school officials to take whatever actions are necessary. I agree to pay for all transportation and emergency care. I understand my child's medications (prescribed and non-prescribed) will be kept in the nurse's office.

Medication must be registered with the school nurse. It must be in the original, unopened, sealed container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug expiration when appropriate.

Parent/Guardian Signature _____ Date _____

Telephone number(s) where you can be reached during school hours _____

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THIS PERMISSION SLIP IS VALID FOR ONE SCHOOL YEAR AND MUST BE RENEWED ANNUALLY