HVCS Authorization for Medication Form

Date:_____ School Year:_____
Student Name: _____Birthdate:_____
Homeroom Teacher: _____Grade: _____Age: _____

Name of Parents/Guardian:_____Emergency Phone: _____
Physician: _____ Physician phone: _____

Medication allergy/sensitivity What reaction would occur?
1._____
2._____
3._____

Food allergy/sensitivity What reaction would occur?
1._____
2._____
3._____

Please list any medication you are providing for your child. This medication will be stored in a secure area within the nurse's station. It is strictly for your child's use and cannot be administered to any other students.

(Child's Name)_____ may receive the medications listed below. The appropriate dosage should be determined according to the package instructions, age and weight of child. I give permission for the volunteer school nurse, school administrator, teacher, or HVCS representative to provide emergency first aid treatment for my child if necessary.

Daily prescription medications to be given at school: (Any changes in medication, dosage, or schedule will need to be recorded in writing in the front office.)

Name of Medication	Dosage	Time Given	Child's Weight

Medication to be administered as needed: (Must be in original packaging)

_____
_____

(Parent Signature)_____ Date: _____

Please make the school aware of your child's use of any epi-pens, inhalers, breathing treatments, etc. All medications must be in the original container. It is the parent's responsibility to make the school office aware of any medication changes for the school year.