

NAPA VALLEY UNIFIED SCHOOL DISTRICT
Health Services

Administration of Medication By School Personnel

(All personnel designated to administer medication shall be trained by a credentialed nurse before administering medication.)

Student's Name _____ School _____

Birthdate _____ Health Plan/Kaiser # _____

TO BE COMPLETED BY PHYSICIAN:

I hereby certify that I have prescribed medication for the above student, to be administered as indicated below:

Medication _____ Dosage _____ To Be Given _____

Medication _____ Dosage _____ To Be Given _____

Duration of medication schedule: From _____ To: _____

Comments: _____

Date: _____

Signature: _____ M.D.

Address: _____

TO BE COMPLETED BY PARENT:

I hereby request that _____ or his/her designee administer the
(Name of School Principal)

medication prescribed by: _____ to my child, _____,
(Name of M.D./D.D.S. (Name of Child)

during school hours.

I understand that I am to **deliver the medication to the school in its original prescription container**, labeled with my child's name and the name of the medication, and that it will be my child's responsibility to go to the school office at the appointed time to receive the medication.

I hereby consent to exchange of information between the named doctor and the school and between the school and the named doctor regarding my child's health needs.

Date

Signature of the Parent/Guardian

THIS FORM IS VALID FOR THE CURRENT SCHOOL YEAR ONLY. This consent may be terminated by parent at any time.

School Name

School Phone