

STEEL VALLEY SCHOOL DISTRICT

PARENTAL CONSENT FORM FOR ADMINISTRATION OF MEDICATION

(FOR USE WHEN DOSAGE CONFORMS WITH RECOMMENDED GUIDELINES)

Pursuant to Steel Valley School District Policy No. 210, the undersigned hereby give(s) (my/our) permission for the school nurse or other designated employee or agent of the Steel Valley School District to dispense the following prescribed medication to my child during school hours as indicated by the Physician Request attached hereto.

Medication/Dosage _____

Time medication is to be dispensed at school _____

Dates medication is to be dispensed (From) _____
(To) _____

Medication must be furnished to school personnel in the pharmaceutical container bearing student identification and instructions for administration as indicated by physician.

Permission for Inhaler/Epi-Pen (only)

- _____ Student may carry & self-administer asthma inhaler
_____ Student may carry Epi-Pen at all times
_____ Epi-Pen/Inhaler to be kept in Nurse's Office at all times

Date: _____

Parent or Guardian

FOR SCHOOL USE ONLY

The following personnel were oriented to this medication:

Date: _____

Administrator