

## Physician Statement of Need

Student's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Student's Address \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

Medication to be administered \_\_\_\_\_

Does this medication have a generic name also? \_\_\_\_\_

Dosage to be administered \_\_\_\_\_

Time or interval at which each dosage is to be administered \_\_\_\_\_

Date to begin administration \_\_\_\_\_

Date to cease administration \_\_\_\_\_

Possible adverse reactions \_\_\_\_\_

\_\_\_\_\_

List of severe reactions that should be reported to the physician \_\_\_\_\_

\_\_\_\_\_

Special instructions for storage of medication \_\_\_\_\_

\_\_\_\_\_

Physician's name \_\_\_\_\_

Physician's address \_\_\_\_\_

Physician's phone number \_\_\_\_\_

Emergency contact information for physician \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Request for Medication Administration

(To be completed by parent of guardian)

**DO NOT RETURN FORM WITHOUT SUPPLYING MEDICATION**

Student Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

Parent Name(s) \_\_\_\_\_ Daytime Phone \_\_\_\_\_

\_\_\_\_\_ Daytime Phone \_\_\_\_\_

Emergency contact \_\_\_\_\_ Phone \_\_\_\_\_

**Please understand that Vineyard Christian Middle School *can not* dispense any medication including over the counter (cough drops, Advil, Motrin, Tylenol, Pamprin, Midol) or prescription medication without parent permission and medication supplied to the school (please see below).**

Medication to be administered \_\_\_\_\_

Dosage to be administered \_\_\_\_\_

Time or interval at which each dosage is to be administered \_\_\_\_\_

I, \_\_\_\_\_ request that Vineyard Christian Middle School administer the above medication to my child in accordance with my request and the physician's statement of need (necessary for prescription medication). I agree to notify the school in writing of any changes in my child's condition with respect to the administration of medication or with any changes to the information provided on the form. **I understand that it is my responsibility to send an appropriate supply of medication to school in its original container, in a zip-lock bag with my child's name on it. Medication provided to the school in any container other than the original will not be accepted.** I understand that the school will have limited liability while administering medication to my child in accordance with a physician's statement of need. The school agrees to keep a written log of medication administered to my child in school throughout the current school year.

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_