SHEPHERD OF THE VALLEY LUTHERAN PRESCHOOL
23838 Kittridge Street * West Hills CA 91307
(818) 347-6784 * Fax (818) 347-9944

REQUEST OF MEDICATION TO BE TAKEN DURING SCHOOL HOURS
2016-2017

***Must be signed by a licensed physician**

Name of student ____
Last First

Sex: ☐ Male ☐ Female Date of birth ____________________ Grade _______

Name of medication ____

Purpose of medication or diagnosis______________________________________

Dosage prescribed __________ Time schedule ____________ Form (tablet/liquid) _______

Date of prescription __________ Length of time to be given ____________________

Special instructions or comments ______________________________________

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The student for whom this medication is prescribed is under my care.

Name of licensed physician (please print) ______________________________

***Signature of licensed physician** ______________________________ **Date** _________

Address ____ Phone ________________

I request that my child, ________________________________, be assisted in taking the above medication at school by authorized persons, and I hereby release Shepherd of the Valley Lutheran School and the member of the staff designated to administer the medication from all responsibility. I will comply with the school's policies and procedures.

Parent signature ____ **Date** ____________

Home phone ______________________________ Emergency phone ________________