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
2017-2018

***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 _______________