MID VERMONT CHRISTIAN SCHOOL

MAILING ADDRESS:
399 West Gilson Ave.
White River Junction, VT 05001-9527

STREET ADDRESS:
399 West Gilson Ave. at Route 4
Quechee, VT 05059

PRESCRIPTION MEDICATION FORM

Name of child: _____ DOB: _____ Grade: _____ Date:_____

All medication to be administered at school must comply with the following school policies:

1. The school nurse or designated staff member **must have this completed form** before medication will be given at school. Your physician may fax this form to MVCS at (802) 295-3748.
2. The school nurse or designated staff member must approve and administer the **first dose** of any medication given at school.
3. The school nurse or designated staff member may delegate administration of subsequent doses to another school staff member.
4. A **parent/adult** must bring the medication to school in an **appropriately labeled pharmacy container**.
5. All medicine must be **kept in the office** unless the health care provider, parent and administrator have given permission for the student to keep the medication for self-administration.

Medication Order:

Medication: _____ Strength: _____

Dosage/Route/Time: _____

Start Date:_____ End Date: _____

Reason for Giving: _____

Physician:_____ Phone number: _____

Parent's Permission for:

I give permission for _____ to share information to MVCS concerning my child's
Healthcare Provider
medication(s).

I give permission for the medication prescribed to be given to my child at school by the school nurse or designated staff member.

Signature of Parent/Guardian: _____ Date: ___/___/___

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Vermont Department of Health ~ Vermont Standards of Practice: School Health Services