



PLEASANT VALLEY

SCHOOL DISTRICT #62

Engage, inspire and empower each student toward academic excellence and citizenship.

This form is only for student's that have medication stored/administered at school.

To be completed by the student's Physician:

Student's Name _____ Birth date _____

Medication Name _____ Dosage _____

Route _____ Frequency _____ Time to be given in school _____

Diagnosis Requiring Medication _____

Intended Effect of This Medication _____

Expected side effects, if any _____

Is this student allowed to carry/self-administer this medication (Inhaler & Epi-pen only) **YES** or **NO**
(Parents must complete a self-administration form for student to carry/self-administer medicine)

Time Interval for Re-Evaluation _____

Other medications student is receiving _____

Physician's Name-Print

Physician's Name-Signature

Phone- Office

Date

Fax-Office

Phone-Emergency

Further Instruction Remarks: _____

Thank You,
Jennifer Morgan, RN, BSN
Pleasant Valley School District Nurse

Forms can be faxed to Pleasant Valley School District
Elementary School Fax 309-674-0165
Middle School Fax 309-679-0652

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www.pv62.com