



HEALTH OFFICE

**OTTER VALLEY UNION HIGH SCHOOL
2997 FRANKLIN STREET
BRANDON, VERMONT 05733
247-6833 X247 FAX 247-4627**

OTTER VALLEY UNION HIGH SCHOOL

Prescription Medication Order and Permission Form

School Year: _____

Name: _____ Grade: _____ Birthdate: _____

Medication: _____

Directions: _____

Reason for giving: _____

Physician's signature _____

If applicable for inhaler:

I Dr. _____ give _____

(student)

permission to carry their inhaler in their sports bag/back pack..

Doctor's Signature

Date

Release of Medical Information

I, _____ give permission for Dr. _____

Parent/Guardian Name

Doctor's Name

to release information regarding immunizations, medications and health concerns to and from Otter Valley Union High School regarding my son/daughter _____.

Parent/Guardian Signature

Date

I hereby give my permission for the above named student to take the medication as prescribed above at school.

Parent/Guardian Signature: _____

This permission shall be in effect as long as the student attends Otter Valley UHS. Sending a written notice of revocation to the school nurse will revoke this permission.

