Virginia School for the Deaf and the Blind
Student Health Center
Phone: 540-332-9027 or 540-332-9026
Fax: 540-332-2244

STUDENT MEDICATION FORM

Student Name: _____Date of Birth: _____

Prescribing Physician:

I certify that the prescribed medications, including over-the-counter medications and supplements, listed below are medically necessary for this student while he/she is attending VSDB. The medications listed below may be administered by school staff. These medication orders will be valid for one year unless otherwise stated; any changes to these prescriptions require new written orders.

Note to prescriber: Parental/Guardian consent in on file in the VSDB Student Health Center for the VSDB nurses and medication aids to administer medications as prescribed below.

Prescribed Medication Name, Dosage, Time, Route, and Reason for Medication:

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____

Physician's Signature: _____ Date: _____

Physician's Printed Name: _____

Telephone: _____ Fax: _____

*NOTE: Please return this form to the Student Health Center at VSDB.