

VALLEY VIEW SCHOOL DISTRICT
School Medication Authorization Form
Physician's Order for Self Medication
During School Hours

STUDENT'S NAME _____ BIRTHDATE _____ GRADE _____

ADDRESS _____ CITY _____

School medications and health care services are administered following these guidelines:

- 1. Physician signed dated authorizations to administer the medication.**
- 2. Parent signed initialed and dated authorization to administer the medication. (See other side of form)**
- 3. The medication is in the original labeled container as dispensed or the Manufacturer's labeled container. (Parent will bring medication to School Health office)**
- 4. The medication label contains the student name, name of the medication, directions for use and date.**
- 5. Annual renewal of authorization and immediate notification in writing of changes.**
- 6. When the medication is discontinued or at the end of the school year, it is the parent's responsibility to pick up the medication by the last day of school. (Medication is discarded at the end of the last day of the school year.)**

To be completed and signed by physician - I have determined that the following medication is necessary for the critical health and well-being of this student and must, therefore, be administered during the school day.

Medication _____ Diagnosis _____

Route _____ Dosage _____ Frequency _____ Time of Administration _____

Intended effect of medication _____

Side effects to watch for _____

Date of Prescription _____ Re-evaluation date _____ Discontinuation date _____

____ This student will self-administer medications in the school health office with **Supervision**.

____ Student has **asthma/EpiPen** medication that he/she needs to carry with him/her and use as directed.

The following describes the circumstances, which indicate that a designated school employee should administer medication:

Physician Signature _____ **Date** _____

Telephone Number _____ **Office Fax** _____

Physician's name printed _____

Office address _____

Parent's Consent for Student Administration of Medication during School Hours

Student's Name _____ Birthdate _____

Parent/Guardian to complete (initial applicable request for your child)

1. _____ (initial) I request that a designated school employee of the Valley View School District be assigned to **supervise my child** while self-administering prescribed medication.
2. _____ (initial) I request that a **designated school employee under specific circumstances as indicated by the physician order administer medication.**
3. _____ (initial) I authorize the School District and its employees and agents to allow my child or ward to possess and use his/ her **asthma medication** (1) while in school, (2) while at school-sponsored activity, (3) while under the supervision of school personnel, or (4) before or after normal school activities, such as while in before-school or after school care on school-operated property, as provided below (**two signatures required, see asterisk***).
4. _____(initial) I further acknowledge and agree that, when the lawfully prescribed medication (Prescribed or over-the-counter order by physician) is so administered or attempted to be administered, I waive any claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.
5. _____ (initial) I understand that I am to provide the school with necessary medication and supplies. I will be responsible for bringing medication to the school and picking up the medication at the end of the school year, by the last day of school.
6. _____ (initial) I give the school permission to contact my child's physician regarding this medication in the event that there is a change of dosage or medication reaction/ emergency.

***Parent/Guardian signature** _____

Parent/Guardian printed name _____

Home telephone # _____ Work telephone # _____ Cell # _____

Emergency contact; Name _____ Telephone # _____

VALLEY VIEW SCHOOL DISTRICT, ITS EMPLOYEES AND AGENTS, SHALL INCUR NO LIABILITY, EXCEPT FOR WILLFUL AND WANTON CONDUCT, AS THE RESULT OF ANY INJURY ARISING FROM THE SELF-ADMINISTRATION OF MEDICATION BY THE ABOVE-NAMED PUPIL. BY SIGNING THIS DOCUMENT, THE PARENTS OR GUARDIAN INDEMNIFY AND HOLD HARMLESS THE SCHOOL DISTRICT AND ITS EMPLOYEES AND AGENTS, AGAINST CLAIMS, EXCEPT A CLAIM BASED ON WILLFUL AND WANTON CONDUCT ARISING OUT OF THE SELF-ADMINISTRATION OF MEDICATION BY THE PUPIL. Parents or Guardians of the pupil understand and agree that the permission for self-administration of medication is effective for the school year for which it is granted and shall be renewed each subsequent year, only upon the fulfillment of the requirements hereof. Provided that these requirements are fulfilled, the above-mentioned pupil with ASTHMA or SEVERE ALLERGIES/ANAPHYLAXIS may possess and use his or her medication while in school, while at a school-sponsored activity, while under the supervision of school personnel or before or after normal school activities such as while in before-school or after-school care or on school operated property.

I HEREBY AUTHORIZE THE SCHOOL DISTRICT TO ALLOW THE ABOVE-NAMED STUDENT TO **SELF-ADMINISTER ASTHMA/EpiPen MEDICATION** IN ACCORDANCE WITH THE TERMS SET FORTH HEREIN.

***Signature of Parent/Guardian** _____ Date _____