# VALDERS AREA SCHOOL DISTRICT
## Permission to Administer Medication at School

**Student Name** _____ **D.O.B.** _____ **Grade** _____

**Parent Name** _____ **Home Phone** _____ **Work/Cellphone** _____

The Valders Area School District is **required** to have written parental/guardian consent for **all** medication administered at school. Prescription medication requires physician directions **and** signature. This order is valid only for the school year 20_____ - 20_____ including the summer session.

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## PARENT

I request that my child receive the following medication administered by appropriately trained school personnel as authorized by me (and my physician if prescription). Specific questions/concerns may be communicated to the physician by a professional staff member serving the school.

| Drug Name | Dosage | Time | Route | Duration |
|---|---|---|---|---|
| | | | | |

I further agree to hold the Valders Area School District and all employees not liable in any and all claims arising from the administration of this medication at school. I agree to notify the school in writing at the termination of this request or of any change in medication.

***Medication must be transported to school by the parent/guardian. According to school policy and DPI, all prescription medications must be in a properly labeled pharmacy bottle and over the counter medications must be in their original containers.**

_____ _____

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

**NOTE:** Any change in medication will require a new form. **For year-long medications**, **consent to administer will expire at the end of each school year**. **Parents are required to pick up all medication at school when discontinued or at the end of school year. Medication left 3 weeks after this time will be properly disposed of.**

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## PHYSICIAN: (for prescription drugs only)

**Prescribing Physician** _____ **MD Phone** _____ **MD Fax** _____

**The following is to be completed by the child's physician prior to administration at school.**

| Medication | Dosage | Time | Route | Duration of Medication |
|---|---|---|---|---|
| | | | | |

1. Is this medication a PRN drug? _____YES _____NO
2. Under what conditions or schedule the drug should be given and repeated: _____
3. Side effects (expected or predicted): _____
4. Purpose of the medication: _____

**Physician Signature**: _____ **Date:** _____

### SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION

Self carry/self administration of **emergency** medication may be authorized by the prescriber if approved by the school nurse.

| PRESCRIBING PHYSICIAN | SCHOOL NURSE |
|---|---|
| Prescriber's authorization for self-carry/self-administration of emergency medication (initial): _____ yes _____ no | Approved by School Nurse for self-carry/self-administration of emergency medication (initial): _____ yes _____ no |
| _____ _____ | _____ _____ |
| **Signature of Prescribing Physician** **Date** | **Reviewed by School Nurse (sign and date)** **Date** |

**PHYSICIAN'S OFFICE: Please fax completed form to Valders Area School District at (920) 775-9509.** Revised 01/01/2022