Valley School District

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

If a health condition or valid reason exists which makes administration of medication advisable when a child is at school and/or under the supervision of school district personnel, the parent/guardian and the child's licensed healthcare provider with prescriptive authority must complete and submit this form prior to any medication being brought to school or administered to the child. Complete one form for each prescription or over-the-counter medication to be administered. Complete a new form anytime the medication order/prescription changes. ***All medication must be transported to and from the school office by the parent/guardian.***

THIS SECTION TO BE COMPLETED BY THE PARENT/GUARDIAN

Student Name: _____ Birthdate: _____

School/Program:_____ Teacher/Grade: _____

I certify that I am the parent or legal guardian of the above identified student. I request and authorize the school to administer medication to my student in accordance with the prescription and/or licensed healthcare provider's instructions for the time period from _____ to _____ (not to exceed the current school year). I affirm medication will be supplied to the school in the original container labeled with student's name, dosage and the time to be dispensed.

X: _____ Date: _____

Printed Name / Signature m/d/y

Home Phone Number: _____Work Number: _____

Cell Number: _____ Address:_____

THIS SECTION TO BE COMPLETED BY THE HEALTHCARE PROVIDER

The student identified above experiences a health condition and/or valid reason which makes administration of the following medication advisable during school hours and/or other times the student is under the supervision of school district personnel.

Medication (name/dosage): _____

Health Condition/Reason: _____

Administration Method/Schedule: _____

☐ Dispense as needed (PRN). Time between doses: _____

Additional Instructions/Possible Side Effects (must be completed if medication is to be dispensed for more than 15 days):_____

_____

_____

I request and authorize that this student be administered the medication identified above in accordance with these instructions from: _____ to _____
(not to exceed current school year).

X: _____ Date: _____

Printed Name / Signature m/d/y

Office Number: _____ Fax Number: _____