CHARTIERS VALLEY
SCHOOL DISTRICT | Inspiring excellence.

Parental Authorization to Administer Medication by Standing Order (2020-21)

(HIGH SCHOOL/MIDDLE SCHOOL ONLY)

Student Name ____ Grade ____________

I hereby authorize the Chartiers Valley School District nurses to administer the following over-the-counter medications, if needed, during the school day **(check all that apply):**

- ☐ Pain reliever - Acetaminophen (Tylenol)
- ☐ Pain reliever - Ibuprofen (Motrin/ Advil)
- ☐ Antacid (such as Tums)
- ☐ Cough drops (such as Halls)

When appropriate, age- and weight-adjusted dosages will be administered. ONLY PILLS are stocked in the Health Office – please consider sending chewables or liquid, if your child can't swallow pills.

I have considered my child's allergies, medical conditions and interactions with other medications, prior to signing this permission form.

Non-prescription medications may be given in a non-emergency situation, in accordance with the prescriptions written by the school physician. I agree that the District and its employees are not to be held liable for giving medication in accordance with this authorization. I agree to hold harmless and indemnify the Chartiers Valley School District and all of its employees against any and all claims, damages, attorney's fees, suits or cause(s) of action, which may be brought against the District or its employees in connection with giving such medicine. This authorization shall be effective unless revoked by me in writing, and must be renewed yearly. I intend to be legally bound by this authorization.

Check one:

☐ I wish to be notified if a dose of medication is administered to my student. Please contact me at the following email address or phone number: ________________________________

☐ It is not necessary to notify me if a dose of medication is administered to my student.

____ ____________________

Parent Name (print) Date

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Parent Signature

v1.1 Rev 9-2020