

AUTHORIZATION TO GIVE MEDICATION AT SCHOOL

GREAT VALLEY SCHOOL DISTRICT

****This form must be completed and sent to the School Nurse if your child needs to be given medication during the school day. This includes all prescription medications and all over-the-counter (OTC) medications (OTC examples: cold/allergy medications, vitamins, herbal supplements.)****

Student's name: _____ Grade: _____

Date of birth: _____ Allergies: _____

List of medications currently being taken by the child: _____

PARENTAL PERMISSION

I, the parent/guardian of _____ request that the School Nurses of the Great Valley School District administer the medication named below. I understand that I must give the first dose of this medication at home, and that all medications must be sent in their original pharmacy containers along with signed physician authorization to administer the medication in school. My signature on this document constitutes a complete waiver of liability claim in any and all respects against the Great Valley School District and its Board of Directors and all of its employees unless the District acts intentionally or willfully in causing harm to the above named student with respect to the administration of medication.

I understand that all medications, unless indicated in writing by the physician, must be kept at the Nurse's office and that my child may not carry medication on his/her person during the school day, nor may it be kept in his/her school bag.

Additionally, I agree to provide the medication to the school in the original pharmacy or physician labeled container. If I am unable to deliver it, I will place the container containing the medication with this completed authorization form in a sealed envelope for transport to the school. I **also accept responsibility to provide a physician's note and my written consent if the medication is to be changed or discontinued.** I give permission for the school and our child's physician to communicate regarding this medication/medical condition.

Signature of Parent/Guardian

_____/_____
Daytime Phone Numbers

Date

****A new authorization form must be signed (Parent & Physician) each school year.****

PHYSICIAN AUTHORIZATION FOR MEDICATION – To be completed by physician

*****Medications will not be given without physician's signature*****

Name of medication: _____ Route of administration: _____

Dose: _____

Time to administer: _____ Discontinuation date: _____

*****Asthma inhaler: The student is qualified and able to self-administer the inhaler and may carry the inhaler during the school day per District Policy** YES NO NOT APPLICABLE

Treatment of: _____

Side effects: _____

Physician Signature

Printed Name of Physician

Date

Physician Phone Number