School Fax

316-755-

**Permission to Administer Medication**
**Valley Center Public Schools Health Services Department**

## Part A – Parent to Complete

Name of Student: _____ Date of Birth: _____ Grade/Teacher: _____

The medication listed below must be taken during school hours as directed by the health care provider. I grant permission for Valley Center Schools to exchange information with my child's health care provider and dispensing pharmacy identified on the medication label as deemed necessary.
I hereby request that Valley Center Schools cooperate with the prescribing health care provider and assist with the administration of medication pursuant to the policy of the Valley Center Schools. I also certify that my child has received at least one dose of the medication requested above and has not had any adverse reactions to it.
I have reviewed the above statements and agree to abide by Valley Center Schools School District Policy regarding the administration of medication/procedures at school. I acknowledge that the school district and its officers, employees, or agents incur no liability for damage, injury, or death resulting directly or indirectly from my child's self-administration of medication, and agree to release, indemnify, and hold harmless the district and its officers, employees, and agents from and against any claims relating to my child's self-administration of medication.

_____ _____ _____
Parent/Legal Guardian Signature | Printed Name of Parent/Legal Guardian | Today's Date

_____ _____
Home Phone | Cell Phone

## Part B – Health Care Provider to Complete

| Medication/Treatment | Dosage / Route | Time / Frequency | Diagnosis(es) / Indication |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Special Instructions: _____

_____

_____ _____
Signature of Physician/APRN/PA | Printed Name of Physician/APRN/PA

_____ _____ _____
Health Care Provider Phone Number | Health Care Provider Fax Number | Today's Date

## REQUEST TO SELF ADMINISTER MEDICATION
## GRADES 6-12- DIABETES, ASTHMA/ANAPHYLACTIC REACTION

I request that my child be permitted to self-mediate at school for the treatment of symptoms related to diabetes, asthma or anaphylactic reaction. I request that my child be permitted to carry the medication with him/her. I understand my child will be responsible for knowing the location of the medications at all times. I acknowledge that the school district and its officers, employees or agents incur no liability for damage, injury or death resulting directly or indirectly from the self-administration of medication and indemnify and hold the school and its officers, employees and agents, harmless from and against any claims relating to the self-administration of such medication. I confirm that my child has been instructed on the proper use of this medication and is able to self-administer this medication on his/her own without school personnel supervision. The student understands the expected response to the medication and what side effects and adverse responses should be reported to an adult. I have provided a written treatment plan for use managing asthma, anaphylaxis episodes, or for a chronic health condition. I have read the Medication Policy for Valley Center USD 262. A request for Administration of Medication at School form must be completed. This serves as written notification in accordance with board policy JGFGBA. The student has demonstrated to the health care provider and the school nurse the skill level necessary to use the medication as prescribed in accordance with the health care providers written treatment plan.
I have discussed the following conditions with my child:

- 1. Immediately tell an adult when having breathing problems or a reaction.
- 2. Never share medication with anyone else.
- 3. Have prescription label on medication.

***This student has demonstrated the skill level necessary to self-administer and carry such medication/treatment.***

☐ **Yes**_____ _____
Signature of Physician/APRN/PA | Medication(s)/Treatment(s) that can be self-administered

# Permission to Administer Medication
## Valley Center Public Schools
## Health Services Department
**Board Policy**:

PRESCRIBED MEDICATION OR OVER-THE-COUNTER MEDICATION WILL BE GIVEN

AT SCHOOL ONLY UPON WRITTEN REQUEST FROM BOTH THE LAWFUL GUARDIAN AND THE PUPIL'S LOCAL ATTENDING PHYSICIAN. THESE WRITTEN REQUESTS ARE **REQUIRED BEFORE ADMINISTRATION** OF EITHER THE SHORT TERM OR MAINTENANCE MEDICATION IS INITIATED.

This written statement will be kept on file at the school for the duration of the stated treatment. Long-term treatment will be updated **annually**. A change in medication dosages requires a new written notification with the attending physician's signature.

**Medications:**

1. Prescribed medication will be provided to the school by the lawful guardian in a properly labeled crushproof container. The label shall give the following information:
    a. Pupil's name
    b. Name of medication
    c. Dosage and directions for administration
    d. Date
    e. Prescribing physician's name.
2. It is the lawful custodian's responsibility to assure the medication and dosage in the container is the same as is described by the label.