DELAWARE VALLEY SCHOOL DISTRICT

AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS

To Physician:

_____ _____ _____

Full name of student | Grade | School

The above-named student must receive the following medication during school hours:

Medication Name & Specific Dosage:_____

Time of Administration:_____ Duration of Admin.: From_____ To_____

Diagnosis:_____

Special Conditions to Observe and/or Emergency Response:

_____

Note: The school nurse or her designee may refuse to administer a medication. The parent/guardian will be notified of this action.

***PHYSICIAN – PLEASE INITIAL BELOW REGARDING SELF ADMINISTRATION OF EMERGENCY MEDICATIONS:**

_____The student **has permission** to carry and self-administer the above ordered asthma inhaler or Epi-pen during school hours. This student is qualified and has demonstrated the ability to self-administer.

****PHYSICIAN – PLEASE INITIAL APPROPRIATE SELECTION BELOW:**

During field trips, the medication noted above may: 1.)_____Be omitted the day of the trip 2.)_____Be given before/after field trip. 3.)_____Be administered by parent/ guardian accompanying child on trip.

Trained staff members may assist in the administration of Epi-Pen and/or asthma inhalers in an emergency situation.

_____ _____ _____

Date | Physician's Signature | Telephone Number

To Parent/Guardian: I authorize the Delaware Valley School District licensed nurses to administer the above medication as prescribed. I do hereby release, discharge, and hold harmless the Delaware Valley School District, its agents and employees, from any and all liability and claim whatsoever for the administration of the above medication to my child should he/she develop any adverse reaction from the medication.

_____ _____ _____

Date | Telephone Number | Parent/Guardian Signature

Revised October 2025

ASTHMA INHALERS AND EPI-PENS (EPINEPHRINE AUTO INJECTORS)
SELF-ADMINISTRATION BY STUDENTS

_____ _____ _____
Student's Name **Grade** **Date**

To self- medicate, the student must be able to: (check all that apply)

_____ 1. Respond to and visually recognize his/her name.
_____ 2. Identify his/her medication.
_____ 3. Demonstrate the proper technique for self-administering his/her medication.
_____ 4. Report to your school nurse as soon as possible to acknowledge having taken the medication.
_____ 5. Demonstrate a cooperative attitude in all aspects of self-administration of medication.
_____ 6. Acknowledge importance of keeping medication in a safe and secure place to prevent another student from accidentally or purposely using the medication.

_____ _____ _____
Name of Medication **Dosage** **Frequency**

The above named student has demonstrated the ability to self-administer the physician-prescribed medication as indicated by the criteria listed above.

_____ _____
Date **School Nurse Signature**

As the parent/guardian of above named student, I relieve the school district and its employees of any responsibility for the benefits or consequences of the above listed medication when it is physician-prescribed and parent/guardian authorized. I further acknowledge that the school bears no responsibility for ensuring that the medication is taken. I am aware that any improper use/sharing of the above named medication will result in the immediate confiscation of the medication and loss of privilege to self-administer if the medication policy is violated.

_____ _____
Date **Parent/Guardian Signature**

I agree to be solely responsible for my medication and to follow the directions for its use as ordered by my physician, as well as the district's medication policy. I acknowledge that this medication is intended for my use only and may not be shared with other students. I am aware that any abuse of this privilege will result in the confiscation of my medication.

_____ _____
Date **Student's Signature**

Revised Nov. 2010