BLACKLICK VALLEY SCHOOL DISTRICT

555 BIRCH STREET
NANTY GLO, PA 15943
DIVISION OF SCHOOL HEALTH

BVES fax: 814-749-8710
BVHS fax: 814-749-8627

AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS

Ideally, all medication should be given at home. It is recognized that at the present time, many students are able to attend regular school because of the effectiveness of medication in the treatment of chronic disabilities and illnesses. However, any student who is required to take medication during the regular school day MUST comply with school regulations. These regulations include the following:

ALL medication will be administered by the school nurse or other authorized personnel under the following conditions:

1. Upon written request from the physician to the school officials that prescription medication must be administered to the student. Included in the request must be the name of the student, name of the medication, dosage, route, and frequency of administration.
2. Parental or guardian written request that all medication to be administered to the student including prescription and non-prescription medications.
3. All medication must be in protective containers that are properly labeled by the physician, pharmacy, or manufacturer.
4. Medication will NOT be accepted in plastic bags, aluminum foil, saran wrap, or plastic containers (such as Tupperware, Rubbermaid, or pill boxes)

Additional notes: For the convenience of you and your child, it would be beneficial that the prescribed medication be processed in two containers by your pharmacist, therefore allowing one prescription to remain at school and one at home. **STUDENTS ARE NOT PERMITTED TO CARRY MEDICATION TO AND FROM SCHOOL. THE SCHOOL IS NOT PERMITTED TO SEND ANY UNUSED MEDICATION HOME WITH STUDENTS. AN ADULT MUST COME TO THE SCHOOL TO PICK UP ANY UNUSED MEDICATION.** These regulations are for the safety and protection of all students in the district. Your cooperation with these regulations will be appreciated.

BLACKLICK VALLEY SCHOOL DISTRICT

AUTHORIZATION FOR MEDICATION ADMINISTRATION

GRADE_____ SCHOOL YEAR_____

_____ must receive the following medication during school to maintain sufficient health to participate in the school program:

Name of medication: _____

Dosage: _____

Route: _____

Time schedule: _____

Length of time (days/weeks): _____

Diagnosis: _____

Possible side effects: _____

I do hereby release, discharge, and hold harmless the Blacklick Valley School District, it's agents and employees, from any and all liability and claim whatsoever for the administration of the above medication to my child should there develop an allergic or other reaction from the medication.

_____ _____

Signature of Parent/Guardian Physician's Signature

_____ _____

Date Date