Phone: 701.749.2570 Fax: 701.749.2313

Maple Valley
School District #4
207 Broadway Street, Tower City, ND 58071
www.maple-valley.k12.nd.us

Dan Larson, Superintendent
Courtney Storhoff, K-12 Principal
Alecia Killoran, Dean of Students
Cassandra Preston, Business Manager

Authorization/Permission for Administration of Prescription Medication

Student Name: _____ Birth Date: _____

Medications and health care procedures required during school, which cannot be managed otherwise, shall be administered **when the following are on file at the school:**

1. Physicians signed and dated authorization including the medication/procedure, reason for receiving, dosage, route of administration, and time given at school.
2. Parent signed and dated authorization/permission to administer the medication/procedure.
3. Medication/equipment delivered to school by parent/legal guardian in the original packaging.
4. Annual renewal of authorization/permission and/or immediate notification, in writing from parent, of any changes.

Medication/procedure shall be administered by qualified staff and a record maintained. Medication/equipment will be stored in a locked secured area.

The above-named student is under my medical supervision. I have prescribed the following:
Medication/Procedure: _____ Dosage: _____ Route: _____
Time Given: _____ Discontinue/Re-Evaluate Date: _____
Reason for Medication/Procedure: _____
Anticipated Reaction/Side Effects: _____
Student Allowed to Self-Administer: **No** **Yes (supervised)** **Yes (unsupervised)**
Physician Signature: _____ Date: _____
Address: _____ Phone: _____

Parent/Guardian Authorization/Permission
I request the above pupil be given the medication/procedure while in school and school related activities. I understand the law provides that there shall be no liability for civil damages because of the administration of medication/procedure where the person administering the medication/procedure acts as an ordinarily reasonable, prudent person would under the same similar circumstances. **I agree to pick up the remaining medication, or it will be properly destroyed.**

Parent Signature: _____ Date: _____
Address: _____ Phone: _____

The Maple Valley Public School District does not discriminate based on race, color, national origin, sex, disability or age in its programs or activities and provides equal access to designated youth groups.