

USD #384
Blue Valley School District

REQUEST FOR ADMINISTRATION OF MEDICATION

The school district medication policy complies with state regulations. This form must be signed by a physician or a licensed prescriber and/or parent/guardian. This form must be completed and returned to the school office before any medication; including over-the-counter drugs can be administered at school. **The medication must be in the original container with appropriate labeling.**

STUDENT'S NAME

SCHOOL

TEACHER

SCHOOL YEAR

MEDICATION

DOSAGE

TIME OF DAY TO BE GIVEN

DATE STARTED

REASON FOR MEDICATION

PERIOD OF TIME TO BE DISPENSED, Example: 10 days, 3 months, Indefinitely

DATE

PHYSICIAN'S SIGNATURE for Prescription Medications Only

Parental Authorization

I hereby give my permission for _____ to take the above named medication at school as ordered. I certify that one dose of the above named medication has been given and there was no adverse reaction from it. I understand that it is my responsibility to furnish this medication. I also understand that any designated school employee who administers this medication to my child in accordance with written instructions from the prescribing health care provider and/or parent/guardian shall not be liable for damages as a result of an adverse drug reaction suffered by the pupil or because of a mislabeled or altered product.

I hereby authorize USD #384 School Nurse to exchange information regarding this request with the above named physician and/or the pharmacy as identified on the affixed pharmacy label as necessary.

Parent/Guardian Signature

Daytime Phone

Date

PLEASE NOTE

- Students who are on on-going medications must complete a new consent form each school year.
- Please refer to the School's Handbook for additional information.

• COMMENTS: _____
