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.

*<u>**PHYSICIAN – PLEASE INITIAL BELOW REGARDING SELF ADMINISTRATION OF EMERGENCY MEDICATIONS:**</u>

______The student **<u>has permission</u>** 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.

****<u>PHYSICIAN – PLEASE INITIAL APPROPRIATE SELECTION BELOW FOR ALL FIELD TRIP MEDICATIONS:</u>**

During field trips, the medication noted above may:1.)_______Be omitted the day of the trip 2.)_______Be given before/after field trip. 3.) <u>N/A</u> Be self administered on field trip by child under direct supervision of District staff member. 4.)_______Be administered by parent/designated guardian accompanying child on trip.

NOTE: IF MEDICATION IS TO BE SENT ON TRIP, ONE DOSE <u>ONLY (</u>IF POSSIBLE) SHOULD BE PACKAGED BY <u>PARENT</u> IN ORIGINAL PRESCRIPTION BOTTLE OR STORE PACKAGE if non-prescription.

_____________ ____ __________________

Date Physician's Signature Telephone Number

To Parent/Guardian: I authorize the Delaware Valley School District 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.

I understand that the medication must be packaged in the original prescription bottle or original store package if it is non-prescription. <u>NO MEDICATION OF ANY KIND</u> can be dispensed to your child at school without a <u>WRITTEN ORDER FROM A PHYSICIAN AND WRITTEN PARENT PERMISSION.</u>

______________ ____________________ ____

Date Telephone Number Parent/Guardian Signature