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 April 2016