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

**ASTHMA INHALERS AND EPI-PENS (EPINEPHRINE AUTO INJECTORS)**

**SELF-ADMINISTRATION BY STUDENTS**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Student’s Name**  **Grade**  **Date**

To self- medicate, the student must be able to: (check all that apply)

\_\_\_\_\_\_ 1. Respond to and visually recognize his/her name.

\_\_\_\_\_\_ 2. Identify his/her medication.

\_\_\_\_\_\_ 3. Demonstrate the proper technique for self-administering his/her medication.

\_\_\_\_\_\_ 4. Report to your school nurse as soon as possible to acknowledge having taken the medication.

\_\_\_\_\_\_ 5. Demonstrate a cooperative attitude in all aspects of self-administration of medication.

\_\_\_\_\_\_ 6. Acknowledge importance of keeping medication in a safe and secure place to prevent another student from accidentally or purposely using the medication.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Name of Medication**  **Dosage** ` **Frequency**

The above named student has demonstrated the ability to self-administer the physician-prescribed medication as indicated by the criteria listed above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Date** **School Nurse Signature**

As the parent/guardian of above named student, I relieve the school district and its employees of any responsibility for the benefits or consequences of the above listed medication when it is physician-prescribed and parent/guardian authorized. I further acknowledge that the school bears no responsibility for ensuring that the medication is taken. I am aware that any improper use/sharing of the above named medication will result in the immediate confiscation of the medication and loss of privilege to self-administer if the medication policy is violated.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Date**  **Parent/Guardian Signature**

I agree to be solely responsible for my medication and to follow the directions for its use as ordered by my physician, as well as the district’s medication policy. I acknowledge that this medication is intended for my use only and may not be shared with other students. I am aware that any abuse of this privilege will result in the confiscation of my medication.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Date** **Student’s Signature**

**Revised Nov. 2010**