PERMIT TO ADMINISTER MEDICATION

Vallivue School District #139

ORDERS FROM AUTHORIZED HEALTH CARE PROVIDER

STUDENT _____ Date of birth ___/___/___

DIAGNOSIS for which medication is being given: _____

- MEDICATION _____
- STRENGTH _____
- DOSE _____
- ROUTE _____
- TIME(S) to be given *DURING THE SCHOOL DAY* _____

TREATMENT PLAN: *Specific directions / Side effects / Emergency response* _____

_____

Student may carry medication & has demonstrated skills necessary to self-administer (Not permitted for controlled medications): ☐ YES ☐ NO

Duration of this therapy (PRN Medication ONLY): ☐ INDEFINITE ☐ CURRENT SCHOOL YEA R

✓ _____ ✓ ___/___/___

SIGNATURE of Authorized Prescriber DATE

_____

PRINTED NAME of Authorized Prescriber

PARENTAL PERMISSION

I give permission for my child to be given the medication prescribed above. I understand that Vallivue School District may designate an employee other than the school nurse to administer the medication.

SELF ADMINISTRATION: If ordered by the physician, I give permission for my child to self-administer medication. I shall indemnify and hold harmless the District and it's employees or agents, for legal fees, costs, and any potential damages concerning self-administration of this medication arising out of any claims brought by the above named child or anyone else.

Any change in this authorization will necessitate a new medication permission form.

✓ _____ ✓ ___/___/___

SIGNATURE of Parent or Legal Guardian DATE