

**AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS  
(Prescription & Over-the-Counter)**

\_\_\_\_\_ must receive and/or have available the following medication(s) while attending  
(Full Name of Student) school during school hours, which could include to and from school, and/or  
while participating in a school-sponsored activity in order to maintain sufficient health to participate in the school program.

Student's Date of Birth: \_\_\_\_\_

Name of medication: \_\_\_\_\_

Prescribed dosage: \_\_\_\_\_ Time schedule for administration: \_\_\_\_\_

Length of time (duration) to be given: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Possible side effects: \_\_\_\_\_

Additional medication currently prescribed: \_\_\_\_\_

Special Conditions: \_\_\_\_\_

Date: \_\_\_\_\_  
(Signature of physician /dentist/certified registered nurse practitioner)

Phone #: \_\_\_\_\_ Address: \_\_\_\_\_

*Orders from C.R.N.P. must include official office stamp on form or must be on official office letterhead that includes physician's name and address.*

**Self-administration authorization section for completion by physician/dentist/certified registered nurse practitioner**  
The above student must carry and may self-administer the above-prescribed emergency medication while attending school during school hours and/or while participating in a school-sponsored activity. In my professional opinion, the student is both competent to self-administer the medication and carry the medication in a responsible manner.  
  
Date \_\_\_\_\_  
(Signature of physician /dentist/certified registered nurse practitioner)

**Parent/Guardian**  
~~I do hereby release, discharge and hold harmless the Pleasant Valley School District, its agent and employees, from any and all liability and claim whatsoever for the administration of the above medication to my child should there develop an allergic or other reaction from the medication. \*~~  
  
Date \_\_\_\_\_  
(Signature of parent/guardian)

**Pleasant Valley School District Medication Policy**

**Whenever possible, parents/guardians are requested to administer medication at home.**

No medication will be dispensed by any school district personnel without the knowledge and verification of the certified school nurse or health room technician. If medication **MUST** be taken during school hours, the following shall be done:

**Medication**

- A. Must be properly labeled and in the original container from pharmacy/doctor.
- B. ~~To ensure the safety of all students, ALL MEDICATION must be brought to school by an adult and given to the school nurse.~~ Students may transport emergency medications (asthma inhalers, Twinjects, EpiPens, insulin "pumps", and the like) to and from school **once this authorization form has been properly completed and returned to the school nurse.**
- C. Only enough medication to last for one (1) month or until the prescription expires should be at school.

**\* Hold Harmless Clause**

As per Board Policy No. 210, the school district, in consideration of dispensation of prescription medications by the school staff who are employed by the school district, hereby covenants and agrees to hold harmless and indemnify all school staff against any and all claims, damages, expenses, attorneys' fees, suits, cause or causes of action in law or equity or any place whatsoever which may be brought against any such school staff because of any negligent act or omission done or not done by such school staff in connection with said dispensation.