Van Buren County Community School District

Parent Authorization for Administration of Medications

(Revised 7/2019)

This form must be completed and returned to the health office before medication will be administered at school.

Student name_____ DOB:_____

Allergies_____

Medication to be given:_____ Reason for medication:_____

Medication dose and route:_____ Time to give medication_____

Special instructions: _____

Physician/Prescriber name for prescription_____ Phone Number_____

_____ _____

*** Physician/ Prescriber signature** (Prescription meds only) * Date

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Requirements for Safe Administration of Medication to Students

- Prescription medications must be prescribed by a legal provider, and include prescriber's signature.
- A parent or legal guardian must provide written authorization and directions for prescription/non-prescription medication
- To maintain the safety of all students, a responsible adult will transport medication to & from the school.
- With exception to emergency relief medications, the first dose of a new medication should be given at home.
- Medication will be in the original container with proper label. Expired or improperly labeled medication will not be given.
  *****For prescription medication, ask the pharmacist to prepare two labeled containers, marking one for "SCHOOL USE" so you have proper containers both at home and school.

On Late start days: _____ I will give medication at home _____Please give medication at school

With early dismissal: _____ I would like medication given at school _____Student will take medication at home

I permit my student to receive these over-the-counter medications if needed at school:

Tylenol, Ibuprofen (Tylenol/Ibuprofen need to be provided by parents in original bottle), hydrocortisone cream, triple antibiotic ointment, calamine lotion, artificial tear eye drops, aloe gel, sunscreen, & insect repellant

____ YES ____ NO

PLEASE READ: I request that the above student be given this medication during school hours. I give my permission for the school nurse, or designee to administer this medication according to the prescription/non-prescription instructions. The student has experienced no previous side effects from this medication. I further understand that it may be in my child's best interest for the health staff to share this medication information with other school staff (teacher, counselor, etc. as necessary) and give permission to do so if needed. The school nurse has my permission to contact the prescribing physician if necessary.

I understand that the law provides that there shall be no liability for civil damages as a result of the administration of medication/health care where the person administering the medication/procedure acts as an ordinarily reasonable prudent person would under the same or similar circumstances. I agree to provide safe delivery of medication and equipment to and from school and to pick up remaining medication and equipment or it will be properly destroyed.

- Medication will be administered by a registered nurse or other qualified designated personnel.
- Please remind your child that he/she is responsible for requesting the medication at the appropriate time.

Parent/Guardian name_____ *****Signature_____

Date_____/_____/_____ Home Phone:_____ Work Phone:_____