Twin Valley School District
Authorization for School Medication Administration
(Form must be completed in it entirety)

Child's Full Name: _____ Grade _____Date of Birth: _____
Drug Allergies: _____
Please list all medications currently being taken by this child:
_____

Physician's Request

Name of Medication: _____

Route of Administration: _____

Dose to be given at school: _____ Time to be given at school: _____

Any instructions? _____

Date to start medication: _____ Date to end Medication: _____

Medication is to be administered:

1. ____ Until Completed Dates to be administered at school:_____
2. ____ Entire school year Daily _____ PRN _____
3. ____ Other: _____

Reason for medication: _____

Side Effects: _____

_____ _____
Physician's Signature **Printed Name**

_____ _____
Date **Phone Number**

Parent Request

I, the parent/guardian of _____ request that the employees (Certified School Nurse or licensed medical professional) of the Twin Valley School District administer the above named medication as prescribed by my child's physician. My signature on this document constitutes a complete waiver of liability claim in any and all respects against the Twin Valley School District and its Board of Directors and all employees unless the District is negligent with regard to any claim for injury in connection with administration of the medication.

Additionally, **I agree to hand deliver** the medication to the nurse's office in the original pharmacy or physician labeled container. I also accept responsibility to provide a physician's note and my written instructions if the medication is to be changed or discontinued. I give my permission for the school and physician to communicate regarding this medication and medical condition.

_____ _____ _____
Date Printed Parent/Guardian Name Parent/Guardian Signature

Rev: 5/2016