Brandon Valley School District
SCHOOL HEALTH SERVICES

Wendy Bunker RN Melissa Garrow RN Margie Hanson RN Renae Peyton RN

Brandon Elementary Fax = 582-2709 Valley Springs Elementary Fax = 757-6795
Brandon Valley Middle School Fax = 582-7206 Brandon Valley High School Fax = 582-2652
Robert Bennis Elementary Fax = 582-8012 Fred Assam Elementary Fax = 332-0947

CONSENT AND REQUEST FOR MEDICATION DURING SCHOOL DAY

The undersigned physician advises that _____Date of Birth_____

A student of the Brandon Valley School District, requires the following medication during the school day:

Name of Medication (trade and generic): _____

Medical Diagnosis: _____

*Specific **time** and **dose** to be taken at school: _____*

Possible adverse reactions: _____

_____ *The student is capable of self administering prescribed medication:* ***Epi pen and/or inhaler***
(Please initial if applicable)

_____ _____ _____
Signature of Physician *Date* *Printed Name of Physician*

Physician Phone #_____ Fax # _____

Is this child Medicaid eligible_____ If yes, provide Medicaid Number_____

Name of Primary Care Physician_____ Is your child also covered under private insurance? Yes No

This medication will be provided to the Brandon Valley School District by the parent or guardian of said child and the undersigned parent or guardian agrees to assume all responsibility for maintaining the supply of medication.

_____ *The undersigned parent or guardian hereby requests the Brandon Valley School District, through Health Services and /or school staff, to administer said child the above described medication and consents to the administration of such medication during the school day. Said parent or guardian hereby expressly relieves the Brandon Valley School District, the School Board of the District and all agents of the District from any liability for the administration of such medication, and further hereby agrees to hold the Brandon Valley School district, the School Board of the District, and all agents of the District harmless from any liability for the administration of such medication. I am responsible to bring medication in labeled bottle directly to personnel in school office. I am responsible to pick up unused medication.*

_____ ***Epi pens and Inhalers only.*** *I authorize my child to self administer his/her prescription medication for asthma and/or anaphylaxis while at school and relieve the school district and personnel of all responsibility.* ***Physician order and statement that student is capable of self administration required.***

The Brandon Valley School District has been approved as a service provider for Medicaid eligible services. State legislature allows school districts to bill Medicaid for physical therapy, occupational therapy, speech/language therapy, psychology services, audiology, and certain nursing services. This does include administering medication during the school day.
I give my permission for the school nurse to discuss with the above named physician observations of effects on my child relating to the above medication, changes in my child as a result of said medication, and any dosage or time changes in medication scheduling. I authorize the release of any medical or other information necessary to process any Medicaid claims submitted for services received at the Brandon Valley School District.

_____ _____
Signature of Parent/Guardian *Date*

Reviewed by School Nurse_____ Date_____