



# BRANDON VALLEY SCHOOL DISTRICT HEALTH SERVICES

Wendy Bunker RN  
Middle School  
Fax: 582-7206

Melissa Garrow RN  
Robert Bennis Elem Fax: 582-8012  
Valley Springs Elem Fax: 757-6795

Jacque Terveer RN  
High School Fax: 582-2652  
Fred Assam Elem Fax: 332-0947

Ardis Moeller RN  
Intermediate School  
Fax: 582-6036

Renae Peyton RN  
Brandon Elem  
Fax: 582-2709

## MEDICATION AND TREATMENT AUTHORIZATION FORM

If this student must take medication during school hours and it cannot be given at home, this form is required. Brandon Valley School District requires this form be completed by the parent for over-the-counter medication and both parent and physician for prescription drugs before administering any medication. Medication must be delivered directly to the health office by the parent/guardian in the original pharmacy container. For the safety of all students, medications are not allowed to be carried/self-administered at school with the exception of epinephrine and emergency inhaler. Renewal of this form is required at the start of each school year.

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade/Teacher: \_\_\_\_\_

Parent/Guardian Name(s): \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Parent Email: \_\_\_\_\_ Student ride bus: Yes  No

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

Name of Medication/Treatment: \_\_\_\_\_

Dosage/Amount Prescribed: \_\_\_\_\_

Route (by mouth, eye drops, intranasal, etc.): \_\_\_\_\_

Time to be Given: \_\_\_\_\_ Frequency (as needed, daily, weekly): \_\_\_\_\_

Duration (start date and discontinue date): \_\_\_\_\_

Possible Side Effects: \_\_\_\_\_

If this is an emergency medication, Epi-Pen, inhaler, etc., is student permitted to self-administer? Yes \_\_\_\_\_ No \_\_\_\_\_

### PRESCRIPTION ONLY:

Physician's Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Phone /Fax: \_\_\_\_\_

\_\_\_\_\_ The undersigned parent or guardian hereby requests the Brandon Valley School District, through Health Services and /or trained school staff, to administer said child the above described medication and consents to the administration of such medication while on school property or at a school-related event or activity. Parent or guardian is responsible for providing medication directly to school personnel in pharmacy-labeled or original bottle, and is responsible for picking up unused medication. I acknowledge and agree that the school shall secure the medication for the student until administration of the medication is necessary, and that in no circumstances shall the medication be stored in the student's locker.

\_\_\_\_\_ **Epinephrine Auto-Injectors and Inhalers only:** I authorize my child to carry & self-administer his/her prescription medication for asthma and/or anaphylaxis while on school property or at a school-related activity or event. **Physician order and statement that student is capable of self-administration required.**

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 injury arising from the administration or self-administration of such medication.

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 school to inform appropriate school employees who would have a need to know of the administration of medication (i.e., school nurse, instructors, teacher aides, school administrators, activity supervisors, bus drivers). 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. I understand that if the student identified herein uses the medication in a manner other than prescribed, the student may be subject to disciplinary action by the school; however, any disciplinary action may not limit or restrict the student's immediate access to the medication.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

Reviewed by School Nurse \_\_\_\_\_

Date \_\_\_\_\_