BRANDON VALLEY SCHOOL DISTRICT
HEALTH SERVICES

Brandon Valley High School
Ardis Moeller, RN
Fax: 605-582-2652
Phone:605-582-3211

Brandon Valley Middle School
Wendy Bunker, RN
Fax: 605-582-7206
Phone: 605-582-3214

Brandon Valley Intermediate School
Libby Burns, RN
Fax: 605-582-6036
Phone: 605-582-6035

Brandon Elementary
Jacque Terveer, RN
Logan Smith, RN
Fax: 605-582-2709
Phone: 605-582-6315

Fred Assam Elementary
Amanda Larson, RN
Fax: 605-582-1505
Phone: 605-582-1500

Inspiration Elementary
Amanda Larson, RN
Fax: 605-582-8595
Phone: 605-582-8590

Robert Bennis Elementary
Sara Ugland, RN
Fax: 605-582-8012
Phone: 605-582-8010

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_____