Pleasant Valley School District #62
Medication Authorization Form (2019-20)

To be completed by the student's parent/guardian:

Student's Name _____ Birth date _____

Teacher_____ Grade _____ Parent/Guardian Name _____

Home Phone _____

Emergency Phone Numbers _____

Allergies _____

Doctor_____ Office location/phone #_____

I hereby confirm that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize the Pleasant Valley District 62 and its employees and agents, in my behalf and stead, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of the school district), lawfully prescribed medication in the manner described above. I ACKNOWLEDGE THAT IT MAY BE NECESSARY FOR THE ADMINISTRATION OF MEDICATIONS TO MY CHILD TO BE PERFORMED BY AN INDIVIDUAL OTHER THAN A SCHOOL NURSE, AND SPECIFICALLY CONSENT TO SUCH PRACTICES. I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the school district, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempt at administration of said medication.

_____ _____

(Parent's Signature) (Date)

This form is only for student's that have medication stored/ administered at school.

To be completed by the student's Physician:

Student's Name _____ Birth date _____

Medication Name _____ Dosage: _____

Route _____ Frequency _____ Time to be given in school _____

Diagnosis Requiring Medication _____

Intended Effect of This Medication _____

Expected side effects, if any _____

Is this student allowed to carry/self-administer this medication (Inhaler & Epi-pen only) **YES** or **NO**
(Parents must complete a self-administration form for student to carry/self-administer medicine)

Time Interval for Re-Evaluation _____

Other medications student is receiving _____

_____ _____
Physician's Name-Print Physician's Name-Signature

_____ _____
Phone- Office Date

_____ _____
Fax-Office Phone-Emergency

Further Instruction Remarks: _____

_____

Thank You,

DeAnna Fitzanko R.N.
Pleasant Valley School District Nurse
309-673-6750 ext. 103
nurse@pv62.com

Forms can be faxed to Pleasant Valley School District
Elementary School Fax 674-0165
Middle School Fax 679-0652

Pleasant Valley School District #62

Medicine Self-Administration Form

I hereby give permission for my child,_____, to possess and use his /her:

(Please circle one or both): Asthma Inhaler EpiPen

at school and at all school-related activities in a manner consistent with the directions for use stated above. I understand that Pleasant Valley School District 62 and its employees and agents are to incur no liability, except for willful and wanton conduct as a result of any injury resulting from self-administration of medication by my child. I indemnify and hold harmless the District and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration or storage of medication. I further understand that the medication must remain in the possession of my child or school authorities at all times. If my child's inhaler or EpiPen is used in an irresponsible or disruptive manner, it may be taken by school authorities.

_____ _____

Parent's Signature Date

*Physician authorization for self-administration/ possession of epi-pen or inhaler must also be completed with this form.