North Fayette Valley Community School District
600 N. Pine Street, P.O. Box 73
West Union, Iowa 52175
Ph: (563) 422-3851 Fax: (563) 422-3854

North Fayette Valley
Prescription Medication Administration Permission Form

Administration of Medication to Students

1. Only medication prescribed by a legal provider will be administered at school.
2. A parent or legal guardian must provide written authorization.
3. Medication will be supplied in the original container with proper labeling including: student's name, name of medication, dose of medication, directions for use, and date. **Expired or improperly labeled medication will not be given.**
4. This consent is only valid for the current school year. Changes/discontinuation of medication require immediate notification in writing.

This form must be completed and returned to the health office before medication will be administered at school.

Student Name: _____ **DOB:** _____

Teacher: _____ **Grade:** _____

Medication Name: _____

Strength of medication: _____ **Dose to be administered:** _____

Time(s) to be given: _____

Reason for Medication: _____

Physician/Prescriber: _____

AM medication – On late start days:

I will give medication at home. _____

Please give medication at school. _____

PM medication – On early dismissal days (e.g., Wednesdays): Medications prescribed for after 2pm will not be given at school unless doctor's order states to do so.

Other special instructions:

_____

_____

I request the above student be given medication at school and school activities (field trips, etc.) by qualified staff according to the prescription or nonprescription instructions and record maintained. The student has experienced no previous side effects from the medication. I further agree that school personnel may contact the prescriber as needed and that medication information may be shared with the school personnel who need to know.

I understand that law provides that there shall be no liability for civil damages as result of the administration of medication where the person administering the medication acts as an ordinary reasonably prudent person would under the same circumstances. I agree to provide safe delivery of medication and equipment to and from school.

Parent Signature: _____ **Phone:** _____ **Date:** _____

For refills, please contact me by (circle choice): Phone Email Text

******Please initial option:*

_____ I will pick up any unused medication at the end of the school year.

_____ Please discard any unused medication.