

**BOYERTOWN AREA SCHOOL DISTRICT  
AUTHORIZATION FOR SCHOOL MEDICATION ADMINISTRATION**

Child's Full Name: \_\_\_\_\_ Grade/Homeroom: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Allergies: \_\_\_\_\_

\*\*\*\*\*

**PHYSICIAN'S REQUEST**

Name of medication (OTC, Prescribed, Vitamins): \_\_\_\_\_

Reason: \_\_\_\_\_ Route: \_\_\_\_\_

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

Time and dose(s) to be given at home \_\_\_\_\_

Time and dose(s) to be given at school: \_\_\_\_\_

Medication is to be administered:

1. \_\_\_\_\_ until completed. Date: \_\_\_\_\_

2. \_\_\_\_\_ entire school year: daily \_\_\_\_\_ prn \_\_\_\_\_

3. \_\_\_\_\_ other: \_\_\_\_\_

\_\_\_\_\_\* I believe this child is able and responsible to carry and self-administer his/her inhaler and/or Epi-Pen during school activities and field trips. S/he has permission to do so and has been instructed on how to self-administer (Gr. K-12).

\_\_\_\_\*\* I believe this child is able and responsible to carry and self-administer the medication during certain field trips and extra-curricular activities. S/he has permission to do so and has been instructed on how to self-administer (Gr.6-12 only).

\_\_\_\_\_  
**PHYSICIAN'S SIGNATURE**

\_\_\_\_\_  
**PRINTED NAME**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**PHONE NUMBER**

\*\*\*\*\*

**PARENT REQUEST**

I, the parent/guardian of \_\_\_\_\_ request that the Boyertown Area School District nurse administer the above named medication as prescribed by my child's physician. My signature on this document constitutes a complete waiver of liability claim in any and all respects against the Boyertown Area School District and its Board of Directors and all employees unless the District is negligent with regard to any claim for injury in connection with administration of the prescribed medication.

Additionally, I agree to hand deliver the medication to the nurse's office in the original pharmacy or physician labeled container. I also accept responsibility to provide a physician's note and my written instructions if the medication is to be changed or discontinued. I give permission for the school and physician to communicate regarding this medication and medical condition.

\_\_\_\_\_\* I believe my child is able and responsible to carry and self-administer his/her inhaler and/or Epi-Pen. I give my permission for him/her to do so (Gr. K-12).

\_\_\_\_\*\* I believe my child is able and responsible to carry and self-administer his/her medication during certain field trips and extra-curricular activities. I give my permission for him/her to do so (Gr.6-12).

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**PARENT/GUARDIAN SIGNATURE**

List all medications currently being taken by this child: \_\_\_\_\_

\* Students in **Grades K-12** may carry and self-administer his/her inhaler and/or Epi-Pen in school & on field trips upon clearance by the school nurse. By signing you agree this child is capable of proper medication administration.

\*\* **This pertains to students in Grades: 6-12 ONLY** in certain situations that will be determined by the administration, doctor, and CSN. The medication policy for extra-curricular activities and field trips must be followed. Please initial if your permission is given.

\_\_\_\_\_ Clearance to carry and self-administer an inhaler and/or Epi-Pen has been given and initialed by the school nurse.