BOYERTOWN AREA SCHOOL DISTRICT
AUTHORIZATION FOR SCHOOL MEDICATION ADMINISTRATION

Child's Full Name: ____ Grade/Homeroom: _______________________

Date of Birth: ______________________ Allergies: ____

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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, on field trips, and at extra-curricular activities upon clearance by their physician, parent and school nurse. 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 on certain field trips and at 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**

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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 during school, extra-curricular activities and on field trips. 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 on certain field trips and at 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: ____

In accordance with Boyertown's Medication policy:

*Students in **Grades K-12** may carry and self-administer his/her inhaler and/or Epi-Pen during school, on field trips, and at extra-curricular activities upon clearance by their physician, parent and school nurse. Your initials indicate that the child is capable of proper medication administration.

** Students in **Grades**: **6-12 ONLY** may carry and self-administer his/her medication on certain field trips and at extra-curricular activities upon clearance by their physician, parent and school nurse. Your initials indicate that the child is capable of proper medication administration.

All medication forms must be completed and on file in your child's school health room before medication can be administered.

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