Nodaway Valley School Medication Administration Authorization
2023-2024 School Year
TO BE COMPLETED BY THE PARENT OR GUARDIAN

I request that my child, _____, date of birth _____, be assisted in taking this medication at school. I will comply with the school's policy and procedures. I agree to, and do hereby hold the school and its employees harmless from any and all claims, demands, causes of action, liability or loss of any sort because of, or rising out of, the acts or omissions of the school or its employees with respect to this medication. I also give the Nodaway Valley school nurse permission to contact the prescribing provider (doctor, nurse practitioner, or physician's assistant) and preferred pharmacy with any questions or concerns. A separate form must be filled out for each medication. This form is effective for a single school year. Thank you for your cooperation.

_____ _____ _____ _____

Printed Name | Parent/Guardian Signature | Date | Phone #

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Name of Medication:_____ Purpose of the Medication:_____

Dosage: _____ How Often: _____

Time to be Given: _____ Dose Form: _____

Start Date: _____ End Date: _____

Preferred Method for Refills: (circle one) SEND WITH STUDENT / PARENT
Preferred Method to Communicate Refills: (circle one) EMAIL / PHONE CALL

If applicable, do you want the medication given on late start days? YES / NO
If applicable, do you want the medication given on early out days? YES / NO
(Note: medication can generally be give 1 hour before and 1 hour after the designated time)
Comments: _____

Students are not permitted to carry medications at school or at school sponsored trips, except for prescribed inhalers and Epinephrine Pens with proper authorization.