# AUTHORIZATION TO GIVE MEDICATION AT SCHOOL

**If medication can be given at home, before or after school hours, please do so. If medication must be given during school hours, this form must be completed and kept on file in the school office each school year.**

**STUDENT'S NAME (please print legibly):** _____

**GRADE:** _____ **CLASSROOM TEACHER:** _____

I authorize medications administration-trained Valley Catholic School (VCS) personnel to assist my child in taking medication at school. I understand that:

- This parent/guardian-signed form constitutes VCS's required written permission for the administration of **all medications, prescription or non-prescription.**
- Medications must be in the original labeled container (pharmacists are usually happy to provide two labeled bottles for this purpose). **Medications sent in unlabeled containers will not be administered.**
- All medications will be stored in a secured cabinet in the school health room.
- The school must be informed of any medication changes. New medication or new doses will not be given unless a new form is completed.
- **Medications must be brought to the office by the parent/guardian, rather than sent to school with the child.**
- Unless it's an emergency situation, or my child has written permission on file to self medicate (e.g. the use of an inhaler), **all medications will be administered only in the school health room by a medications administration-trained school staff member.**
- If my child refuses to take the medication, the medications administrator will not force him/her to do so, but I will be called about the missed dose.
- Unused medication will be disposed of unless picked up within one week after medication is discontinued or the school year has ended.

---

NAME OF MEDICATION: _____

TYPE OF MEDICATION (please circle): Non-Prescription Prescription IF PRESCRIPTION, Rx #: _____

IF THIS IS AN INHALANT, DO YOU WANT YOUR CHILD TO HAVE PERMISSION TO CARRY THE INHALER ON THEIR PERSON AND TO SELF-ADMINISTER THE MEDICATION WHEN NECESSARY (please circle)? Yes No [***If "yes", you must fill out a separate permission form to carry an inhaler.***]

DOSAGE _____ BY (please circle): Mouth Ear Eye Nose Skin Inhalation

TIME(S) TO BE GIVEN @ SCHOOL _____ DURATION: Start Date: _____ End Date: _____

REASON FOR MEDICATION: _____

POSSIBLE SIDE EFFECTS, IF ANY: _____

_____

**IF PRESCRIPTION MED., PHYSICIAN'S NAME** (please print): _____

**IF PRESCRIPTION MED., PHYSICIAN'S SIGNATURE:** _____

**IF PRESCRIPTION MED., PHYSICIAN'S PHONE NUMBER:** _____

---

**I hereby release, discharge and further agree to indemnify, hold harmless, or reimburse the Sisters of St. Mary of Oregon Campus Schools Corporation, the Sisters of St. Mary of Oregon Ministries Corporation and their directors, officers, employees, agents and volunteers from any and all claims, actions, suits, losses, costs, expenses and liability in case of accident or any other mishap in administering such medication or because of side effects, illness or any other injury which might occur to my child through administering such medication.**

---

**Parent's/Legal Guardian's Signature**_____ **Date** _____

**Home Phone** _____ **Work Phone** _____ **Cell Phone:** _____

[*This authorization applies only to the medication listed above and only for this school year. This also authorizes the exchange of information, if necessary, between appropriate school personnel and/or my child's licensed health care provider.*]

---

*8/21/2012*