TRINITY VALLEY SCHOOL

PRESCRIPTION MEDICATION ADMINISTRATION AUTHORIZATION

(Required if student will or may need to have prescription medicine during school hours/activities.)

Student Name:_____ **Grade:**_____

Only medication deemed necessary to enable a student to remain in school may be given at school. Please make every attempt to give your children the necessary medication at home, before school and at bedtime. If necessary, medication(s) will be given at school under the following conditions.

- Must be in original, properly labeled container (medicine sent in unlabeled baggies will not be given)
- First/initial dose of a prescribed medication must be given at home in case of an unexpected reaction
- May be given by a medically untrained person, in the absence of the school nurse
- Must be kept in the TVS Nurse's Office in a locked cabinet, except for students whose doctor requires them to carry medication on their person
- Only the amount of medication needed during school hours should be provided (except for inhalers)
- Physician and parent signatures are required for prescription medications to be administered

I request that my child be assisted in taking the medicine(s) described below at school by the School Nurse and/or Athletic Trainer as also authorized by my physician.

Medication Name	Medication Dose	Medication Time at School	If PRN Describe Indications	Med Route	Begin And End Date

Asthma Inhaler Self-Administration - to be completed by Health Care Provider.
This student may/may not (circle one) carry and administer their own asthma medication.

Signatures:

Physician:_____ Date:_____

Printed Physician Name:_____

Parent/Guardian:_____ Date:_____

Printed Name:_____