RIVER VALLEY SCHOOL DISTRICT MEDICATION ADMINISTRATION FORM

☐ River Valley High School	Phone: 608-588-2554	Fax: 608-588-2827
☐ River Valley Middle School	Phone: 608-588-2556	Fax: 608-588-2026
☐ River Valley Early Learning Center	Phone: 608-546-2228	Fax: 608-588-8566
☐ River Valley Elementary School	Phone: 608-588-2559	Fax: 608-588-2550

Student Name: _____ Birth date: _____ Grade: _____

Parent/Guardian Name: _____Phone: _____

PRESCRIPTION MEDICATIONS: MUST BE COMPLETED AND SIGNED BY A PHYSICIAN

Diagnosis: _____

DAILY Medication:

Medicine	Dose	Route	Frequency	Duration	Side effects to be reported to Physician
1.					
2.					

PRN Medications: Administer for the following symptoms: _____

Medicine	Dose	Route	Frequency	Duration	Side effects to be reported to Physician
1.					
2.					

INHALERS: ☐ Student may carry inhaler and self-administer.

I agree to retain the power to direct, supervise, decide, inspect, and oversee the administration of the above medication(s).

Medical Provider Signature:_____ Date:_____

Medical Provider Nam (please print)_____ Telephone #:_____

Address:_____

NON-PRESCRIPTION MEDICATIONS

Parent or guardian must complete the information below.
If the dose exceeds the recommendations on the bottle/package, a physician's order is required.

Medication	Dosage	Frequency	Considerations	Duration
1.	*			
2.	*			
Other medications provided at school with parent/guardian permission: ☐ Tyl Tylenol ☐ Ibu Ibuprofen **For students with frequent ailments (headaches, allergies, stomach aches, etc.) that require frequent use of medication, parent will be required to supply medication for school. Medication will be administered according to product instructions unless specified**			*Dosing per bottle instructions for student's age	

Parent Permission for Administration of Medication

I hereby give my permission to authorize personnel of the River Valley School District to give medication to my child as described above. I agree to hold River Valley School District, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school. I hereby give permission to the school nurse to contact the child's physician, if needed. I give consent for this information to be shared with staff members with an educational right to know. I agree to contact the school nurse if any changes occur with the above request.

Parent/Guardian Signature:_____ Date:_____