RIVER VALLEY SCHOOL DISTRICT

MEDICATION REQUEST AND AUTHORIZATION FORM 5330

(A new request/authorization form must be submitted each school year or for each new medication.)

Student: _____ Date of Birth: _____ Grade: Select

Physician's Name: _____ Phone #: _____ Fax #: _____

Address of Practice: _____

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To be completed by the physician or authorized prescriber:

Name of medication: _____ Diagnosis/reason for medication: (OPTIONAL)_____

Form of medication/treatment: Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other ☐

Instructions (Schedule and dose to be given at school): _____

Start medication on the date this form is received: ☐ Other date: _____

Stop medication at the end of the school year: ☐ Other date/duration: _____

Medication is for episodic/emergency events only (Asthma, bee stings, diabetes, etc…) ☐ If yes then…

This student is both capable and responsible for self-administering this episodic/emergency medication:

Yes-supervised ☐ Yes – unsupervised ☐ No ☐

This student may self-possess this episodic/emergency medication: Yes ☐ No ☐

Restrictions and/or important side effects: _____

None anticipated: ☐

Special storage requirement: None ☐ Refrigerate ☐

Please indicate if you have provided additional information: as an attachment: ☐

Physician Signature: _____ Date: _____

To be completed by Parent/Guardian:

The parent is to notify the school in writing if the medication, dosage, schedule or procedure is changed or eliminated.

A new request/authorization form must be submitted each school year or for each new medication.

I request that (name of child) _____ receive the above medication at school.

I request that (name of child) _____ be allowed to self-possess the above medication (Emergency Meds Only)

I request that (name of child) _____ be allowed to self-administer the above emergency medication.
(in the presence of two authorized staff members)

Parent/Guardian Signature: _____ Relationship: _____Date: _____

Date form received by school personnel: _____