VALLEY CITY PUBLIC SCHOOL DISTRICT #2 VALLEY CITY, NORTH DAKOTA 58072 MEDICATION AUTHORIZATION PARENTAL CONSENT	Descriptor Code ACBD-E2	1st Reading 8/9/18
	Adopted 8/9/18	Revised/Rescinded

MEDICATION AUTHORIZATION PARENTAL CONSENT

NOTE: Provide the school with a new form each school year, and any time there is a change in the student's health information.

Student's last name: _____

Student's first name: _____

Gender: _____ Grade: _____

Date of birth: _____/_____/_____

EMERGENCY CONTACT INFORMATION

Parent/guardian's emergency contact name and number: _____
_____ ☐ Home ☐Work ☐Cell

Parent/guardian's emergency email address:

_____

Alternate family member's emergency contact name and number: _____
_____ ☐ Home ☐Work ☐Cell

Relationship to student: _____

Primary healthcare provider's name and phone number:

_____

Secondary healthcare provider's name and phone number (if applicable):

_____

Student's pharmacy name and phone number: _____

_____

STUDENT HEALTH INFORMATION

Does the student have any known allergies? ☐ Yes ☐ No

If yes, list below all known allergies. _____

_____

The student has knowledge of his/her known allergies and has been educated on the signs and symptoms of allergic reactions and how to prevent them.

☐ Yes ☐ No

Will the student be taking more than one medication at school or while otherwise under the school's supervision? ☐ Yes ☐ No

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PRESCRIPTION MEDICATION AUTHORIZATION (K – 12)

Prescription medications must be in the original pharmacy-labeled container and include the name and phone number of the pharmacy. The container must list, in a legible format, the name of the student, student's date of birth, name of the prescription medication, dose, expiration date, storage instructions (if any), administration directions, number or amount of medication included, and the container must list or be accompanied by active ingredients in a legible format. If any prescription medication is given to a student prior to sending the prescription to school, the parent/guardian must indicate how much medication remains in the container. All prescription medication must be hand delivered by a parent/guardian to the designated district official at their school office.

OVER-THE-COUNTER MEDICATION

K-6 grade parents will be called every time over-the-counter medication is given.
Over-the-counter medication must be in the original labeled container.

FOR STUDENTS GRADES 7-12 ONLY

1. This student is permitted to be administered the following over-the-counter school district provided medications: ☐ Tylenol – Extra Strength 500 mg. (1-2 tabs)
   ☐ Tylenol – Regular Strength 325 mg. (1-2 tabs)
   ☐ Ibuprofen 200 mg. (1-3 tabs)

FOR STUDENTS GRADES 9-12 ONLY

2. This student may carry the following over-the-counter medication: ☐ Yes ☐ No
   ☐ Tylenol – Extra Strength 500 mg. (1-2 tabs)
   ☐ Tylenol – Regular Strength 325 mg. (1-2 tabs)
   ☐ Ibuprofen 200 mg. (1-3 tabs)

3. This student has received instruction in self-administering this over-the-counter medication in a secure manner. In addition, the student has received education on any side effects or adverse interactions associated with the over-the-counter medication and how to prevent them: ☐ Yes ☐ No

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CONFIDENTIALITY WAIVER

NOTE: Completion of this section by a parent/guardian authorizes the disclosure and/or use of your child's individually identifiable health information consistent with law (including HIPAA).

I _____ (parent/guardian's name) authorize (name of agency and/or health care providers): _____
to provide health information from _____(Students name)
medical record to: _____(name of school).
The disclosure of health information is required for the school to provide medication and/or oversee my child's self-administration of medication.

Requested information shall be limited to the following: ☐All minimum necessary health information; or ☐ Disease/condition-specific information as described:

_____

This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for the remainder of the school year from the date of signature (if no date entered).

Law prohibits the school from making further disclosure of my child's health information unless the school obtains another authorization form from me or unless such disclosure is specifically required or permitted by law. I understand that I may revoke this authorization at any time. My revocation must be in writing, signed by me, and delivered to the healthcare agencies/persons and school listed above. My revocation will be effective upon receipt but will not be effective to the extent that the school or others have acted in reliance of this authorization.

I understand that the school will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the school for the purpose of providing safe, appropriate, and least-restrictive educational settings and school health services and programs.

I have a right to receive a copy of this authorization. Signing this authorization is required in order for my child to obtain medication services in the educational setting.

_____ _____
Parent/guardian's signature Date
NOTE: A copy of this confidentiality waiver must be sent to the student's healthcare provider when requesting information.

PARENTAL CONSENT

I am the parent or guardian of _____. I give my permission for him/her to take medication as listed on this form and/or on the medication check-in form (ACBD-E3)(ACBD-E4) while in _____ School.

I acknowledge that I have read, understand, and agree to comply with the school district's medication program policy. I certify that the information included on this form is accurate to the best of my knowledge. I hereby release
Valley City Public Schools School District and its employees from any claims or liability connected with its reliance on this permission and agree to indemnify, defend, and hold them harmless from any claim or liability connected with such reliance.

Parent/Guardian Signature Date

STUDENT CONSENT (9th – 12th Grade ONLY)

I acknowledge that I have read, understand, and agree to comply with the school district's medication program policy. I also acknowledge and agree to comply with the district's drug and alcohol free schools policy, which contains restrictions related to medication, including rules prohibiting me from giving medication (prescription and over-the-counter) to other students.

Anytime I believe that I am having a reaction to my medication, I will report this information to my teacher or another school employee.

If I have received permission to carry medication, I agree that I will not leave the medication unattended or unsecured and accessible to other students.

Student's signature Date