

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

This authorization will expire at the end of the school year, or earlier as determined by the health care provider.

Student _____	Birth Date _____	Grade _____
Prescribing Health Care Provider's Name/Phone _____		
CHECK THE BOX THAT APPLYS TO YOUR CHILD:		
<input type="checkbox"/> I request that a trained school staff member assist my child to take the medication described below, according to the health care provider's instructions. The medication will be stored for the student in the health room.		
For self-administration of medication: <i>I acknowledge that the School District shall incur no liability as a result of any injury arising from my child's self-administration of his/her medication. I shall indemnify and hold harmless the District and it's employees or agents against any claims arising out of the self-administration of medication by my child.</i>		
<input type="checkbox"/> For Inhaler or EpiPen: My child has my permission, and is capable and responsible enough, to carry and self administer an asthma inhaler or EpiPen as authorized below. See #9 on the back.		
<input type="checkbox"/> Applies to CHIMACUM & PORT TOWNSEND School Districts, Grades 6-12 ONLY: My middle or high school age child has permission to carry and self administer a single dose/day of this medication in an original container. See # 9 on the back.		
_____	_____	_____
Date	Parent/Guardian Signature	Home Phone
		Emergency Phone

THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH CARE PROVIDER

Please note: **ONLY ONE MEDICATION PER FORM.**

By WAC, school staff are ONLY authorized to administer oral medication, asthma inhalers and EpiPens.

Diagnosis or condition for which medication is given:		
Method of administration: <input type="checkbox"/> oral tablet/capsule <input type="checkbox"/> oral liquid <input type="checkbox"/> asthma inhaler <input type="checkbox"/> nebulizer <input type="checkbox"/> EpiPen		
Name of medication and dose:		
Time of administration for DAILY medication:		
If given AS NEEDED, specify length of time between doses and indication for usage:		
<input type="checkbox"/> For an asthma inhaler or EpiPen ONLY, this student may carry and is capable of self-administration.		
<input type="checkbox"/> Oral medication for a 6 th – 12 th grades ONLY: This student may carry and self-administer <u>a single dose</u> per day of this medication. (Carrying and self-administration of controlled drugs is <u>never</u> allowed at school.)		
Possible side effects of medication:		
Emergency procedure in case of serious side effects:		
This authorization is valid: <input type="checkbox"/> For the current School Year; or <input type="checkbox"/> From _____ <input type="checkbox"/> To _____		
I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated, as there exists a valid health reason that makes administration of the medication advisable during school hours.		
_____	_____	_____
Date	Health Care Provider Signature	Health Care Provider Name (PRINT)

Please see reverse side for Required Guidelines on Providing Medication for School Administration.

Adapted from The Administration of Medication in Schools and RCW 's: 28A.210.260, 28A.210.270, 28A.210.370 8/07