

**AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL****ESTA PORCION DEBE SER COMPLETADA POR EL PADRE DE FAMILIA/GUARDIAN**

Nombre del Estudiante \_\_\_\_\_ Fecha de nacimiento \_\_\_\_\_

Escuela \_\_\_\_\_ Maestro \_\_\_\_\_ Grado \_\_\_\_\_

Nombre del Médico \_\_\_\_\_ Teléfono del Médico \_\_\_\_\_

Yo certifico que soy el padre de familia, guardián legal, u otra persona en control legal del estudiante identificado arriba y solicito y autorizo a la escuela para que administre el medicamento prescrito para el estudiante identificado arriba de acuerdo con las instrucciones observadas por el médico. **El medicamento será suministrado a la escuela en su envase original.**

Firma del Padre de familia/guardián \_\_\_\_\_

Teléfono de Casa \_\_\_\_\_ Teléfono de Emergencia \_\_\_\_\_

**THIS PORTION TO BE COMPLETED BY THE PHYSICIAN**

Name of Medication

Strength / Dosage

Method of Administration

Time to be Taken

Diagnosis for which medication is given: \_\_\_\_\_

Possible side effects of medication: \_\_\_\_\_

**Inhaler Use:** (in accordance with chapter 28A.210 RCW)

Please complete for all students planning to store an inhaler at the school office.

- Student has been instructed in the correct and responsible use of inhaler.
- Student may carry and self-administer inhaler.
- Student does not demonstrate ability sufficient to self-carry or self-administer inhaler at school.

**Recommendation:** Please provide to parent or guardian a prescription for backup inhaler and spacer to store at school for use if the student forgets or misplaces medication.

**Epi-Pen Use:** (in accordance with chapter 28A.210 RCW)

WSD requires authorized health care provider authorization to be on file for students requiring Epi-Pen.

- Student has been instructed in the correct and responsible use of Epi-Pen.
- Student may carry and self-administer Epi-Pen.
- Student does not demonstrate ability sufficient to self-carry or self-administer Epi-Pen at school.

**Recommendation:** Please provide to parent or guardian a prescription for backup Epi-Pen to store at school for use if the student forgets or misplaces medication.

I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated above for the period \_\_\_\_\_ to \_\_\_\_\_ (not to exceed current school year) as there exists a valid health reason which makes administration of the medication necessary during school hours or during such time that the student is under supervision of school officials. School personnel that are not medically trained may administer such medication.

Authorized Health Care Provider's Signature

Telephone

Date

Name (Print or Type)

Address