

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

Student's Name _____ Birthdate _____

School _____ Teacher _____ Grade _____

Physician's Name _____ Physician's Phone _____

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student and request and authorize the school to administer the prescribed medication to the above-identified student in accordance with the prescription of doctor's instructions. **Medication must be supplied to the school in the original container and must be transported by parent or guardian.**

Parent/Guardian Signature _____

Home Phone _____ Emergency Phone _____

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 _____