AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student's Name: _____ Birthdate: _____
School: _____ Grade: _____

This portion to be completed and signed by a licensed health professional if it is necessary to dispense medication during school hours

Name of Medication	Dosage	Method of Administration	Time of Day

If pm specify the length of time between doses: _____
Reason for medication to be given during school hours: _____
_____
Permission to carry inhaler: Yes____ No____ EpiPen: Yes ____ No ____
Insulin: Yes ____ No ____ (insulin injection may not be delegated to unlicensed staff)

Possible side effects of medication: _____

Emergency procedure in case of serious side effects:_____
_____

I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated above from _____ to _____. There exists a valid health reason which makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials. Such medication may be administered by trained school personnel.

Date of Signature	Licensed Health Professional	Name (print or type)

Phone	Fax

Address	City	State	Zip

This portion to be completed by the parent/guardian

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student. I request and authorize the school to administer the above identified medication to the above identified student in accordance with the prescription or instructions from a licensed health professional.

MEDICATION MUST BE SUPPLIED TO THE SCHOOL IN THE <u>ORIGINAL CONTAINER</u>; <u>AND</u> THE WRITTEN AUTHORIZATION <u>MUST MATCH EXACTLY</u> THE INFORMATION ON THE CONTAINER.

I understand and agree that because of schedule and other responsibilities, a dosage or dosages may be delayed or missed. Permission granted to exchange medication information with the nurse.

Date	Signature	Home Phone	Work Phone

Reviewed by: _____ (School Nurse) Date: _____

Revised: June 2000; Thurston County School Health Advisory Board (Word:Meds)