AUTHORIZATION FOR MEDICATIONS TO BE TAKEN AT SCHOOL

The following section is to be completed by the PARENT/GUARDIAN: (please print)

School _____ Fax # _____ Grade _____

Student's Name _____ _____ Initial _____
(Last) (First)

Birth Date _____ ID # _____ Gender _____

_____ _____ _____
(Health Care Provider's Name) (Address) (Phone & Fax)

Please check only one box:

___ I request that authorized persons at school assist my child in taking the medicine(s) described below. I also give my permission for exchange of information between the school district staff and the health care provider.

___ I request that my child be allowed to self-administer medication. I also give my permission for exchange of information between the school district staff and the health care provider. I shall hold harmless and indemnify the school and Seattle Public School District's officers, employees, and agents against all claims, judgments, or liabilities arising out of the self-administration and carrying of medication by my child.

___ I am signing this form on my own behalf (RCW 26.28.015 or RCW 70.02.130). I also give my permission for exchange of information between the school district staff and the health care provider.

_____ _____ _____ _____
(Date) (Parent/Guardian/Student Signature) (Home Phone) (Emergency Phone)

The following section is to be completed by the HEALTH CARE PROVIDER: (please print)

I have determined that the medication named below is advisable during the school day.

Diagnosis for which medication is given: _____

Name of medicine: _____ Dose: _____

__ Tablet/Capsule __ Liquid __ Inhaler __ Injection __ Nebulizer __ Other _____

If medicine is to be given DAILY, at what time? _____

If medicine is to be given WHEN NEEDED, describe indications: _____

_____

How soon can it be repeated? _____

Is child authorized to medicate himself/herself? __ yes __ no

If "yes", student has been trained by health care provider and is safe to self-administer. __ yes __ no

Length of time this treatment is recommended: _____

Possible side effects: _____

Emergency procedure in case of serious side effects: _____

Date: _____ Health Care Provider's Signature: _____

Adapted from the American Academy of Pediatrics, HEO150

Whenever possible we encourage medication doses to be scheduled during non-school hours. For those students who need medication at school the following is required by Washington State Law and **must be completed and on file before any medication may be given.**

ALL MEDICATIONS TO BE ADMINISTRATED AT SCHOOL REQUIRE A REQUEST FROM A LICENSED HEALTH PROFESSIONAL.

OVER-THE-COUNTER MEDICATION/PRODUCTS

- ~ Authorization for Medications to be Taken at School Form completed by both parent AND a licensed health professional with prescriptive authority. Must be in its original container.

SHORT-TERM PRESCRIBED MEDICATION - 15 school days or less

- ~ Authorization for Medications to be Taken at School Form completed by both parent AND licensed health professional with prescriptive authority.
- ~ Medication must be in a properly labeled container (see list) from the dispensing pharmacy.
  - ~ Student's Name
  - ~ Name and Strength of Medication
  - ~ Time and Method of Administration
  - ~ Length of Time/Days to be Given

LONG-TERM PRESCRIBED MEDICATION - 16 school days or more

- ~ Must meet all of the requirements for short-term medication PLUS ADDITIONAL DETAILED INSTRUCTIONS ARE REQUIRED FROM YOUR LICENSED HEALTH PROFESSIONAL.

REMEMBER: ONLY ORAL MEDICATIONS CAN BE GIVEN BY NON-NURSE SCHOOL STAFF. EPI-PENS ARE THE ONLY EXCEPTIONS.

Thank you for your cooperation.

_____ _____

(School Nurse) (Date)

JL:jb:5/23/08:wp:medicine.020