Authorization for Administration of Medication at School

Student Name:_____Birthdate: _____Grade: _____

Medication Policy: A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of a medication. Prescription medication must be in a container labeled by the pharmacist or prescriber. Non-prescription medication must be in the original container with the label intact. An adult must bring the medication to the school and is responsible for ensuring there is an adequate, unexpired supply available. The school nurse (RN) will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.

This Portion to be Completed by Licensed Healthcare Provider (LHP):

Requests for **Prescription Medication** to be administered at school (for a period of greater than 15 days) need to be completed by a Licensed Healthcare Provider (LHP) in accordance with RCW 28A.210.260

Name of Medication	Dosage	Method of Administration	Time of day to be taken

Diagnosis: _____ ICD-10:_____
If given 'as needed' (prn), specify the length of time between doses: _____ 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_____ (Not to exceed current school year), as there exists a valid health reason that makes administration of the medication advisable during school hours.

Licensed Healthcare Provider Signature: _____Telephone #:_____

Printed Name: _____ Prescriber ID:_____ Address:_____

Verbal Order Taken by School Nurse:_____ Date:_____

This Portion to be Completed by Parent/Guardian:

Requests for **Over the Counter Medication** can be completed by the Parent/Guardian

Name of Medication	Dosage	Methods of Administration	Time of day to be taken

Diagnosis/Reason for medication: _____
Additional instructions:_____

I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated above from_____ to_____ (Not to exceed current school year), as there exists a valid health reason that makes administration of the medication advisable during school hours.

SELF CARRY/SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL: Self carry/self administration medication may be authorized by the parent and must be approved by the school nurse.

Parent authorization for self carry/self administration of medication: _____ Date:_____

School RN approval for self carry/self administration of medication: _____ Date:_____

I have reviewed the information regarding medication at school and request/authorize the school to administer medication to my student in accordance with the instructions provided until otherwise notified.

Parent authorization for administration of medication: _____ Phone #:_____Date:_____