

MEDICATION AUTHORIZATION/ORDER (RCW 28A.210.260)

For oral medication (including inhaler & G-Tube Meds) and eye/ear drops and topical medication kept in health room.

Date: _____ **Student Number:** _____
Student Name: _____ **DOB:** _____
School: _____ **Grade:** _____

Medication should be given at school only when absolutely necessary. Whenever possible the parent/guardian and licensed health care provider (LHCP) are urged to design a schedule for giving medication outside of school hours. It is understood that trained unlicensed personnel may administer medication. All medication, other than self carry inhalers, will be locked in the health room. The medication to be given at school must have a written order signed by a licensed health care provider and have a parent/guardian signature. **The medication must be in the original, properly labeled container. This includes any over the counter medication and office samples.** The school accepts no responsibility for adverse reactions when the medication is dispensed in accordance with the licensed health care provider order.

THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH CARE PROVIDER:

DIAGNOSIS: _____

MEDICATION (OTHER THAN INHALER)

Medication	Dosage	Route	Time/Interval	Side Effects
		Oral		
		Oral		
		Oral		
		Eye drop		
		Ear drop		
		Topical		

Allow student to self-administer eye drops, ear drops, and/or topical (ointments, creams, lotions)

INHALERS ONLY

Medication: _____ # puffs: _____ every _____ hours as needed.

Medication: _____ # puffs: _____ every _____ hours as needed.

If NO relief may repeat: Medication: _____ #puffs: ___ after ___ minutes. May repeat ___ # of times.

Special inhaler instructions for illness: _____

Special inhaler instructions for activity (PE/recess): _____

The student may self-carry and has been instructed in proper use and dosage and understands not to share medication.

Student may not self-carry

I request and authorize that the above named student receive the above identified medication(s) in accordance with the instructions indicated, beginning with the _____ day of _____, 20____ (not to exceed the current school year). There exists a valid health reason, which makes administration of the medication advisable during school hours. **All medications (including office samples) must be in the original container, labeled with the name of the student, the dosage, and the time to be given.**

► _____
Licensed Health Care Provider Signature Date Office Phone Office FAX
 Printed Name of Licensed Health Care Provider: _____

THIS PORTION TO BE COMPLETED BY PARENT/GUARDIAN:

Due to unforeseen circumstances, I understand a dose may be delayed or missed. When notified by school personnel that medication remains after the course of treatment I will collect the medication from the school or understand that it will be destroyed. The school assumes no responsibility for self-carried inhalers. In the event a safety issue arises, the school administrator, and/or registered nurse have the right to notify the parent/guardian/student and discontinue the self-medication privilege. The medication will then be kept in the health center and dispensed by trained staff. Allow my student to self-carry inhaler. **DO NOT** allow my student to self-carry inhaler.

Allow my student to self administer eye drops, ear drops, and topicals (ointments, creams, lotions).

► **Parent/Guardian Signature** _____ Date: _____ E-Mail: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

► **Student Signature if allowed to self carry inhaler:** _____ Date: _____

District RN signature: _____ Date _____