Everett Public Schools
Health Services

MEDICATION AUTHORIZATION/ORDER (RCW 28A.210.260)

For oral medication (including inhaler & G-Tube Meds) and self administered eye/ear drops and topicals 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 oral medication. Student must be able to self administer/apply topicals, and eye/ear drops. 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 drops (student must be able to self administer)*		
		Ear drops (student must be able to self administer)*		
		Topicals (student must be able to self administer)*		

*by ordering ear/eye drops or topicals, the LHCP acknowledges the student has been instructed/skilled to self administer.

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). I understand that unlicensed personnel may not apply topicals or eye/ear drops, and the medication will be locked in the health room.*

► **Parent/Guardian Signature** _____ Date: _____ E-Mail: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Oral Medication 07 Rev:10/00, Reviewed 4/10
District RN signature: _____ Date_____

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

District RN signature: _____ Date_____