AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Snohomish School District No. 201, Snohomish, WA 98290

Washington State Laws authorize Snohomish School No. 201 to allow administration of prescription medication and/or in student's possession during school hours. A written medication order from an authorized prescriber and written authorization from the parent/guardian is required.

Due to safety concerns each student is individually evaluated based on their health and developmental level. We reserve the right to discontinue administration of the medication if it becomes impracticable or unsafe, and/or withdraw permission to self-administer if the student demonstrates an inability to responsibly possess and self-administer such medication. The parent/guardian will be contacted as soon as possible and in advance of the discontinuation of the medication.

Medications must be in the original container dispensed by a physician/pharmacist and only a one day supply will be allowed in the student's possession. If samples of medication are to be given, they must be labeled with the name of the student, dosage, and time to be given.

Parent/Guardian Authorization

Name of Student:_____ **Sex:**_____ **Date of Birth:**_____

Name of School:_____ FAX # _____**Grade:**_____**Teacher**:_____

I request that the medications listed below be administered to my child by the District or, if approved by the prescriber, be self- administered by my child. This signed authorization will allow the District Nurse to contact my child's Health Care Provider, who signs this authorization, regarding the condition for which this medication is being administered and use of this medication(s). I acknowledge that the District shall incur no liability as a result of any injury arising from the District's administration of oral medications in substantial compliance with the prescription. I also indemnify and hold harmless the District and its' employees or agents against any claims arising out of the self-administration of this medication by my child.

Parent/Guardian Signature:_____ **Date:**_____

Home Phone: (____)_____ **Emergency Phone:** (____)_____

Prescriber's Authorization

Condition for which medication is being administered: _____

	Authorized to Self-Administer
1. Medication: _____ Dose: _____ Time: _____ Frequency: _____	❒* Yes ❒ No
2. Medication: _____ Dose: _____ Time: _____ Frequency: _____	❒ *Yes ❒ No
3. Medication: _____ Dose: _____ Time: _____ Frequency: _____	❒ *Yes ❒ No

Side Effects: 1._____ 2. _____ 3. _____

*A trained staff member may assist in the administration this medication in the event my child is unable to self-administer.

If I have checked "yes" above, I verify that the student has demonstrated to me the skill level necessary to use the medication and the device necessary to administer the medication.

There exists a valid health reason which makes administration of medication and/or in possession of this medication by the student advisable during school hours or during such time that the student is under the supervision of school officials for the period commencing with_____day of_____, 20_____ through the_____day of_____, 20 _____. This request is valid no longer than the current school year.

I accept responsibility for monitoring the medication prescribed for desired or adverse side effects. I will be monitoring the ongoing health status of this patient. If prescription medications are listed above, they are within the scope of my prescriptive authority.

Licensed Health Care Provider Signature:_____**Date:** _____

Printed Name:_____ **Phone:** (____)_____**FAX:** (____)_____

I, District Nurse, verify that the student has demonstrated to me the skill level necessary to use the medication and the device necessary to administer the medication and agree that the student should be in possession of his/her medication during school hours.

Date:_____**Signature of District Nurse (RN):**_____

I, School Principal, agree that student shall be in possession of his/her medication during school hours.

Date: _____**Signature of Principal:** _____

This authorization does not exceed the current school year.