RIDGEFIELD SCHOOL DISTRICT
unlimited possibilities

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student's Full Name (Print): _____School Year: _____
(Last) (First) (MI)
DOB: _____ Grade: _____ School: _____ School Fax: _____

THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH PROFESSIONAL (LHP) PRESCRIBING WITHIN THE SCOPE OF THEIR PRESCRIPTIVE AUTHORITY

Name of Medication:_____
Dosage/Frequency: _____
Diagnosis or reason for medication: _____
If given PRN, specify the length of time between doses: _____
Possible side effects of medication: _____
What observable side effects do you want us to report: _____
Student is capable of carrying/administering inhaler ___ Yes ___ No and/or Epi-pen ___ Yes ___ No
Repeat Epi-Pen in ____ minutes? ____ Yes ____ No

I request and authorize that the above-named student be administered the above identified oral medication or Epi-Pen injection in accordance with the instructions indicated above from _____ to _____ (not to exceed current school year), as there exists a valid health reason which makes administration of the medication advisable during school hours.

_____ _____
Licensed Health Professional Signature Date of Signature

_____ _____ _____
Licensed Health Professional Name (Print or Type) Telephone Fax

Please Note:

1. **Prescribed medication must be provided in the container labeled by the pharmacist with the name of your student, name of medication, dosage and frequency in which medication is to be given.**
2. **Over the counter medication must be in the original container.**
3. **If samples of medication are to be given they must be labeled with name, dosage and time to be given.**
4. **All medications must be checked into school health room by *parent/guardian/adult student.***

THIS PORTION TO BE COMPLETED BY PARENT/GUARDIAN/ADULT STUDENT

I request and authorize the school to administer medication to the above identified student in accordance with the health care provider's instructions. I may revoke this authorization by writing to the student's school district or filling out a revocation form available from any school in the district. If I did, it would not affect any actions already taken by the school district based upon this authorization. Once health care information is disclosed, the person or organization that received it may re-disclose it in conformance with applicable laws. Confidentiality of information provided to the student's school district is protected by the federal Family Education Rights and Privacy Act. I acknowledge that in according with RCW 28A.210.270 I will not hold the district and its employees or agents liable in any claims arising out of the self-administration of medication by the student. You have my permission to communicate with this health care provider in order to make arrangements for the care and supervision of the student.

I give the health care provider permission to fax this form to the school ___yes ____no
Permission for the student to carry and self-administer inhaler _____yes _____no
Permission for the student to carry and self-administer Epi-pen _____yes _____no

_____ _____
Parent/Guardian/Adult Student Signature Date of Signature

_____
Parent/Guardian/Adult Student (Print or Type)

☐ **Ridgefield High School**	☐ **South Ridge Elementary**	☐ **Union Ridge Elementary**	☐ **View Ridge/ Sunset Ridge**
Office: 360-619-1320	Office: 360-619-1505	Office: 360-750-7608	Office: 360-619-1301
Fax: 360-619-1395	Fax: 360-619-1559	Fax: 360-750-7659	Fax: 360-619-1397