SCHOOL MEDICATION AUTHORIZATION FORM

St. John/Endicott Cooperative Schools

St. John Schools
301 Nob Hill, St. John, WA 99171
Phone: 509-648-3336 Fax: 509-648-3451

Endicott Schools
308 School Drive, Endicott, WA 99125
Phone: 509-657-3523 Fax: 509-657-3521

Student's Name_____ DOB:_____ Grade_____ Date_____

Parent/Guardian Home Phone #_____ Work# _____

PHYSICIAN ORDER TO ADMINISTER MEDICATION AS INSTRUCTED TO THE ABOVE STUDENT. THE SCHOOL DOES NOT SUPPLY ANY MEDICATIONS.

Emergency Medications (Epi Pens/Inhalers) Require a Separate Form

Name of Medication:_____

(ONLY 1 MEDICATION PER FORM, PLEASE)

Doseage_____

Route (method of administration) _____

Time/Frequency (If PRN specify length of time between doses)_____

Reason for medication_____

Possible side effects_____

Start Date:_____ **Stop Date:**_____

(ALL AUTHORIZATIONS EXPIRE AT THE END OF THE SCHOOL YEAR)

Physician's Signature_____ **Date**_____

Physician's Printed Name_____ Phone #_____

PARENTAL PERMISSION: I request this medication to be given to my child as prescribed by the physician above. I understand that my child's medication must be supplied to the school by the parent in an original container that has not passed its expiration date. The medication will be kept in the locked medication cabinet/drawer in the office.

Parent's Signature_____ **Date:**_____

Parent's Printed Name_____

Field Trip Medication Record- ***(School Use Only)***

Signature of trained person giving the medication:_____

Date and Time medication was given:_____

Date **Time**