WAITSBURG SCHOOL DISTRICT

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student Name: ______________________________ Birth Date: ______________

School: ______________________________ Grade: ______________

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

Name of Medication	Dosage	Method of Administration	Time to Be Taken
____________	______	____________	_______

Diagnosis or reason for medication: ______________________________

If given PRN, specify the minimum length of time between doses: ______________________

This student has been instructed and has demonstrated the ability to properly manage self-administration of medication.

I request and authorize this student to carry their medication. ______Yes ______ No

I request and authorize this student to self-administer their medication. ______Yes ______ No

Possible side effects of medication: ______________________________

Emergency procedure in case of serious side effects: ______________________

I request and authorize that the above-named student be administered the above identified medication in accordance with the instructions indicated above from __________ (date) to __________ (date) **(not to exceed current school year)** as there exists a valid health reason which may make administration of the medication advisable during school hours.

Date of Signature Licensed Health Professional (LHP)

Telephone Number Name **(please print)**

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

- I request this medication to be given as ordered by the licensed health professional.
- I give Health Services Staff permission to communicate with the medical office about this medication. I understand that oral medications may be administered by non licensed staff members who have been trained and are supervised by a Registered Nurse.
- Medication information may be shared with school staff working with my child and 911 staff, if they are called.
- All medication supplied must come in its originally provided container with instructions as noted above by the licensed health professional.

I request and authorize my child to carry and/or self-administer their medication. ______ Yes ______ No

Date of Signature______________________ Parent/Guardian Signature ______________________

Telephone Numbers: ______________(home) ______________ (work) ______________(cell)

Reviewed by School Nurse ________________ Date: ________________