WOODLAND SCHOOL DISTRICT NO. 404

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL 2008/2009

Student's Name: _____ School Fax: 360-225-7970

DOB: _____ School: Woodland Primary__ Gr: _____ Teacher: _____

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/self-administering inhaler: _____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 (not to exceed current school year), **from _____ to _____** as there exists a valid health reason which makes administration of the medication advisable during school hours.

_____ _____

Licensed Health Professional signature Date of signature

_____ _____

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 the child, the name of the medication, the dosage and frequency in which the medication is to be given. All medications must be transported to the school office by a parent.**
2. **Over the counter medications must be in the original container.**
3. **If samples of medication are to be given, they must be labeled with the name of the student, dosage, and time to be given.**

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I request and authorize the school to administer medication to the above identified student accordance with the health care provider's instructions. I understand that every reasonable effort will be made by school staff to administer the medication in a timely manner. You have my permission to communicate with this health care provider in order to make arrangements for the care and supervision of my child.

I give the health care provider permission to fax this form to the school. _____**Yes** _____**No**

Permission to carry & self administer inhaler (if authorized by LHP) _____**Yes** _____**No**

Parent/Guardian signature:_____Date: _____

Parent/Guardian phone # :_____Cell or Work phone # :_____