East Valley School District #361
Health Services
3830 N. Sullivan Road, Bldg 1, Spokane Valley, WA, 99216 (509) 924-1830

School Year ____________

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student Name _________________________________ Birthdate ____

Teacher/Grade _________________________________ School____

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THIS PORTION TO BE COMPLETED BY LICENSED HEALTH PROFESSIONAL (LHP) WITH PRESCRIPTIVE AUTHORITY

Name of Medication/Strength	Dosage	Method of Administration	Time of day to be taken

Diagnosis ____

If given "as needed" (prn), specify the length of time between doses ____

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 oral medication 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 medication advisable during school hours.

________________________ X____
Date of Signature Licensed Health Care Professional with Prescriptive Authority

Telephone Number _____________ Fax Number_________________ Name ___________________________________
(Print or Type)

Please Note: If samples of medication are to be given, they must be labeled with the name of the student, dosage and time to be given.

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THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I have reviewed the parent information regarding medication at school and request/authorize the school to administer medication to the above identified student in accordance with the doctor's instructions for the period from ___________ to _____________ (not to exceed current school year). Medication will be supplied to the school in the original container labeled with student's name, dosage, and the time to be dispensed. I authorize the exchange of information about my child's medication between the LHP office and the school nurse.

Note: If you child requires medication for asthma or anaphylaxis, contact your school nurse. An Asthma or Severe Allergy Care Plan which includes medication orders is required.

Date of Signature ______________ **Parent/guardian signature** ____

Telephone Number: Home ________________ Work ________________________ Cell___________________________

This record must be kept for a period of 8 years.

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Parent Information on Medication at School

Pursuant to the State of Washington laws, administration of ORAL, TOPICAL, EYE, AND EAR MEDICATION may be provided at school if all conditions are met.

I. All Medication

1. Must be brought to the school office by the parent and not the student.
2. Pills need to be broken prior to being brought to school for half dosages.
3. Medication will be counted by school staff and parent, and acceptance log signed by both, for all medication brought to school.
4. Medication left at school shall be destroyed the last day of school, according to district policy.

II. Prescription Medication

1. An "Authorization" form must be completed and signed by the parent and licensed healthcare professional prescribing within the scope of his/her prescriptive authority.
2. All medication must be in the original prescription bottle and properly labeled with the student's name, name of medication, medication strength, medication dosage, medication route, date and time of day to be given, and the name of prescribing licensed healthcare professional.
3. The directions on the "Authorization" form must match the directions on the prescription bottle.
4. Sample medication must also be properly labeled and in the original container or package.

III. Non-Prescription Medication

(e.g. cough drops, vitamins, aspirin, cough syrup, topical preparations, or any over-the-counter medication)

1. An "Authorization" form must be completed and signed by the parent and licensed healthcare professional prescribing within the scope of his/her prescriptive authority.
   a. No medication shall be given without this "Authorization" form.
   b. Non-prescription medication must be in the original package and must be labeled by the parent with the student's name, name of medication, medication strength, medication dosage, medication route; date and time of day to be given, and the name of prescribing licensed healthcare professional.

IV. Administering medication 15 Days or Less

1. An "Authorization" form must be completed and signed by the parent
2. The prescribing licensed healthcare professional must write, on either a prescription blank or "Authorization" form, a request for medication to be administered at school.

V. Administering Medication 15 Days or More

1. An "Authorization" form must be completed and signed by the parent and licensed healthcare professional prescribing within the scope of his/her prescriptive authority.
2. This "Authorization" form must contain complete prescribing licensed healthcare professional instructions. A prescription blank is not sufficient for medications over 15 days.

VI. Injectable Medication - Signed "Authorization" form must accompany medications.

1. Injectables – If a student is susceptible to a pre-determined, life-endangering situation, school personnel may assist the student with an auto-injection, i.e. Epinephrine Auto Injector. Emergency medical personnel from the community may be called upon to administer injectable medications.

VII. Inhalers and Epinephrine

1. Student's requiring medication for Asthma **must** complete a *School Asthma Plan and Medication Orders* form.
2. Student's requiring an Epinephrine Auto Injector **must** complete a *Severe Allergy Reaction Plan and Medication Orders* form.
3. Inhalers & Epinephrine Auto Injector's - The prescribing licensed healthcare professional and parent must state in writing on the specific form, if the student is to carry an inhaler or epinephrine auto injector. The school nurse will also be part of this decision. The school shall not be responsible for documentation of medication carried and self administered by the student.

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