AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Kelso School District recognizes that students must take medication at school in certain cases; however, adjusting administration schedules that allow for medication to be given outside of school hours is recommended. When a health condition requires prescription or non-prescription (over-the-counter) medication administration during school hours, authorization must be given by the student's parent or legal guardian and accompanied by written instructions and signature of the prescribing licensed health care provider. Only school district personnel trained and delegated by the District Nurse are authorized to administer medication at school.

THIS SECTION TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDER

Student Name: _____ DOB: _____

Name of Medication: _____ Dosage: _____ Time/Frequency: _____

☐Tablet/Capsule ☐Liquid ☐Inhaler ☐Epi-Pen ☐Other _____

For PRN Medication indicate frequency: _____ Symptoms: _____

☐Medication may be repeated when and if: _____

Reason for Medication: _____

Additional Instructions: _____

Relevant side effects of medication: ☐ None expected ☐ Yes, please explain: _____

Length of time for Medication Administration: ☐ Current School Year ☐ Other: From: _____ to: _____

I authorize that the above-named student be administered the above identified medication in accordance with the instructions indicated as there exists a valid health reason which makes administration of the medication advisable during school hours.

*Student has been trained by health care provider and is safe to self-carry and self-administer medication. ☐ Yes ☐ No

_____	_____	_____
Signature of Licensed Health Care Provider	Date	Clinic Name
_____	_____	_____
Name (Printed)	Telephone Number	Fax Number

Please Note:

1. Prescribed medication must be provided in the original and current pharmacy labeled container with the student's name, the name of the medication, the dosage and time/frequency of medication administration.
2. Over the counter medications must be in the original container
3. Medications must be brought to the school by the parent/guardian.

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I request and authorize designated school personnel to administer medication to the above identified student in accordance with the health care provider's instructions above. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I understand that at the end of the school year, an adult must pick up the medication. I authorize communication with the health care provider as allowed by HIPAA and FERPA. I agree to indemnify and hold harmless the school district and its employees who may administer and/or monitor any medication.

I agree that my student has been trained and is capable to self-carry and self-administer medication. ☐ Yes ☐ No

_____	_____	_____
Parent/Guardian Signature	Name (printed)	Date of Signature

FOR SCHOOL USE ONLY

☐ Yes ☐ No District Nurse approval for self-carry/self-administration of medication.

Medication available: ☐ Health Room ☐ On Student _____ ☐ Other _____

Form Rcv'd:_____ ☐ Entered in Database ☐ Exp. Date √ Rvw'd by District Nurse: _____