Authorization for Administration of Medication at School

Hoquiam School District

Student Name _____ Birthdate _____
School _____ Date _____

The following portion of the authorization must be completed and signed by a licensed health care professional.

Name of Medication	Dose	Route	Time to be taken (must be specific or "prn")
_____	_____	_____	_____
_____	_____	_____	_____

If "PRN" specify the length of time between doses: _____
Reason for medication to be given during school hours: _____
Possible side effects of medication: _____
Emergency procedure in case of side effects: _____

Permission to carry (check): **Inhaler** □ Yes □ No, **EpiPen**: □Yes □ No, **Insulin** □ Yes □ No (insulin injection may not be delegated to unlicensed staff).

I request and authorize that the above named student be administered the above identified medication in accordance with the instructions noted above from _____ to _____ (authorization can not exceed one school year). There exists a valid health reason which makes administration of the medication necessary during school hours, or during such time that the student is under the supervision of school officials. Such medication may be administered by the school nurse or trained school personnel.

Licensed Health Professional Signature: _____ Date: _____
Print Name: _____ Phone: _____ Fax: _____
Address: _____, _____, _____

This portion of the form is to be completed by Parent/Legal Guardian

I certify that I am the parent, legal guardian or other person in legal control of the above identified student. I request and authorize the school to administer the above identified medication to the above identified student in accordance with the prescription and instructions from a licensed health professional.

I further understand and agree that because of schedule and other responsibilities, a dose or dosages may be delayed or missed. Permission is granted to exchange medication information with the nurse and between the nurse and authorizing physician.

Parent/Guardian Signature _____ Date: _____
Home Phone Number: _____ Work or Cell: _____

All medication MUST be supplied in the original container and delivered to school by parent/guardian. Written authorization must match EXACTLY with information on the container. Medication can not be held over the summer, any unused medication not picked by parent/guardian at the end of the school year will be destroyed.

Reviewed by School Nurse: _____ Date:_____
Student demonstrated proper use of device to RN: □ Yes □ No Date Demonstrated _____
Device: _____