Wenatchee Public Schools

AUTHORIZATION TO ADMINISTER MEDICATION AT SCHOOL

Student:_____ Birthdate:_____
School:_____ Teacher:_____
Condition Requiring Medication: _____

TO BE COMPLETED BY LICENSED HEALTH PROFESSIONAL WITH PRESCRIPTIVE AUTHORITY:

Name of Medication	Dosage	Method of Administration	Time(s) of day to be given
Duration of order IF less than the current school year: / / until / /			

Inhaler Use: (in accordance with chapter 28A.210 RCW)
Please complete for all students planning to use an inhaler at school.
☐ Student has been instructed in the correct and responsible use of inhaler.
☐ Student may carry and self-administer inhaler.
☐ Student does not demonstrate ability sufficient to self-carry or self-administer inhaler at school.
Recommendation: Please provide order for spacer at school for children under 12 years of age.

Epi-Pen Use: (in accordance with chapter 28A.210 RCW)
WSD requires authorized health care provider authorization to be on file for students requiring Epi-Pen.
☐ Student has been instructed in the correct and responsible use of Epi-Pen.
☐ Student may carry and self-administer Epi-Pen.
☐ Student does not demonstrate ability sufficient to self-carry or self-administer Epi-Pen at school.
Recommendation: Please provide to parent or guardian a prescription for backup Epi-Pen to store at school for use if the student forgets or misplaces medication.

I request/authorize the above-named student to be administered the above-identified medication in accordance with the instructions as indicated as there exists a valid health reason which makes administration of the medication advisable during school hours or during such times that the student is under the supervision of school officials.

Licensed Health Provider's Signature:_____ Date:_____
Licensed Health Provider's Name:_____ Phone:_____

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APPROVAL OF PARENT OR GUARDIAN
I hereby authorize school personnel to administer the medication above to be given as ordered by the student's Licensed Health Provider (LHP). I understand that School Personnel who are not medically licensed, but trained may administer the above medication.

Parent/Guardian's Signature:_____ Date:_____

Note to Parents: All medications must be **delivered** to the school **by a parent/guardian.** All **medications** must be in the **original container.** Prescription labels must include the student's name, name of the medication, dosage and mode of administration, an expiration date, and the name of the LHP. If the medication is an **over-the-counter medication**, the label must include the name of the medication, dosage, mode of administration for age/weight, and expiration date.