Eastmont School District ~ Educational Health Services

School: FAX (509)

Authorization of *ORAL MEDICATION* at School

Student's Name:		Birth date		**Grade:**	

THIS PORTION MUST BE COMPLETED BY THE PHYSICIAN / DENTIST

Name of Medication	*Dosage*	*Route*	*Time of Day*	*Time Interval if PRN*

Student 1) MUST carry inhaler or medication on his / her person? ______ YES _______NO ***and*** 2) Student has been instructed on inhaler use by the HCP and is capable of self-administration of medication _______ YES _______ NO

Initial of HCP

Reason for medication to be given during school hours ______________________________

Anticipated action ______________________________

Possible side effects of medication ______________________________

Emergency procedure in case of serious side effects ______________________________

Medications student is allergic to ______________________________

Does the student take any medication at home that prevents serious health risks?________ Yes _______ NO

If yes, please describe: ______________________________

I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated above for the period commencing with the _______ day of________

Date of Signature **Health Care Provider Name** ***Please Print***

Telephone Number **Fax Number** **Physician's/Dentist's Signature**

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.* RCW 28A.210.260

THIS PORTION OF THE FORM IS TO BE COMPLETED BY THE PARENT / GUARDIAN

I certify that I am the parent, or legal guardian in legal control of the above identified student and request and authorize the school to administer the above identified medication in accordance with the prescription, or doctor's instructions, for the period beginning the ______**day of** _______ **201__** through **the________day of** __________**, 201__** (not to exceed one school year).

I understand the district policy on administration of medication at school and am in agreement to its content. Medication must be supplied to the school in the original container labeled with instructions on how it will be given at school. I understand and accept that at times the doses of medication may be delayed or missed due to occasional conflicts in the student's schedule. I give my consent to release the above identified student for further medical or hospital care in the event of an emergency. I give my consent for School District staff to exchange information with the above health care provider and associated school staff, regarding the above student for the duration of the school year.

Date of Signature Parent/Guardian Name

Please Print

Home Work Telephone # Cell Signature:

Student has demonstrated to school nurse correct administration of inhaler ______________________________

school nurse signature