

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

<i>Name of Medication</i>	<i>Dosage</i>	<i>Route</i>	<i>Time of Day</i>	<i>Time Interval if PRN</i>

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 Cell Signature:
 Telephone #

Student has demonstrated to school nurse correct administration of inhaler _____
school nurse signature