Entiat School District 509-784-1314
2650 Entiat Way. Entiat, WA 98822 FAX 509-784-2986

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student Name: _____ Birth Date: _____

School: _____ Grade: _____

THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH PROFESSIONAL (LHP) PRESCRIBING WITHIN THE SCOPE OF THEIR PRESCRIPTIVE AUTHORITY

(Please write clearly in print in order that the instructions are legible)

Name of Medication	Dosage	Method of Administration	Time to Be Taken

Diagnosis or reason for medication: _____

If given PRN, specify the minimum length of time between doses: _____

I request and authorize this student to carry their medication.
☐ Yes ☐ No

I request and authorize this student to self-administer their medication.
☐ Yes ☐ No

In agreeing that this student may self-administer medication, I concur that this student has been instructed and has demonstrated the ability to properly manage self-administration of medication.

Possible side effects of medication: _____

Emergency procedure in case of serious side effects: _____

I request and authorize that the above-named student be administered the above identified medication in accordance with the instructions indicated above from _____ (date) to _____ (date) **(not to exceed current school year)** as there exists a valid health reason which makes administration of the medication advisable during school hours.

_____ _____
Date of Signature Licensed Health Professional (LHP)

_____ _____
Telephone Number Name **(please print)**

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

- I request this medication to be given as ordered by the licensed health professional.
- I give Health Services Staff permission to communicate with the medical office about this medication. I understand that oral medications may be administered by non-licensed staff members who have been trained and are supervised by a Registered Nurse.
- Medication information may be shared with school staff working with your child and 911 staff, if they are called.
- All medication supplied must come in its originally provided container with instructions as noted above by the licensed health professional.

I request and authorize my child to carry and/or self-administer their medication. ☐ Yes ☐ No

_____ _____
Date of Signature Parent/Guardian Signature

Telephone Numbers: _____(home) _____ (work) _____(cell)

Registered Nurse Reviewed: _____ on _____