ENTIAT SCHOOL DISTRICT

Paul Rumburg Elementary School 509.784.1314 / fax 509.784.2986
Entiat Jr/Sr High School 509.784.1911 / fax 509.784.2986

AUTORIZACION PARA ADMINISTRAR MEDICAMENTO INHALADO EN LA ESCUELA

ESTA PORCION DEBE SER COMPLETADA POR EL PADRE DE FAMILIA/GUARDIAN

Nombre del Estudiante_____ Fecha de nacimiento _____

Escuela_____Maestro_____Grado_____

Nombre del Médico_____Teléfono del Médico _____

Yo certifico que soy el padre de familia, guardián legal, u otra persona en control legal del estudiante identificado arriba y solicito y autorizo la auto-administración del medicamento prescrito para el estudiante identificado arriba de acuerdo con las instrucciones del médico.

El medicamento será suministrado a la escuela en su envase original.

Firma del Padre de familia/guardián_____

Teléfono de Casa _____ Teléfono de Emergencia _____

THIS PORTION TO BE COMPLETED BY THE PHYSICIAN

NAME OF MEDICATION	STRENGTH/DOSAGE	METHOD OF ADMINISTRATION	TIME TO BE TAKEN
_____	_____	_____	_____

Diagnosis for which medication is given:_____

Anticipated action:_____

Possible side effects of medication: _____

Emergency procedures 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 for the period _____ to _____ (not to exceed current school year) as 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 supervision of school officials. School personnel that are not medically trained may administer such medication.

_____ _____
Physician's/Dentist's Signature Date of Signature

_____ _____ _____
Name (Print or Type) Telephone Number Address

_____
Address