

Lake Washington School District #414  
Health Services  
**AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL**

Student's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

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***This Portion to be Completed by Health Care Provider/ Dentist***

<u>Name of Medication</u>	<u>Dosage</u>	<u>Method of Administration</u>	<u>Time of Day To Be Given</u>
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Diagnosis \_\_\_\_\_

If given PRN, specify the length of time between doses. Indicate if student will self-carry inhaler/epipen on his/her person.

Anticipated action \_\_\_\_\_

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. Medication orders are good for the current school year only, unless a shorter period is specified. There exists a valid health reason which makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials. ***Medication may be administered by medically untrained school personnel.***

\_\_\_\_\_  
Health Care Provider/ Dentist Signature

\_\_\_\_\_  
Date of Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Phone Number

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***This Portion of the Form Is To Be Completed By Parent/ Guardian***

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student. I request and authorize the school to administer the above identified medication to the above identified student in accordance with the health provider's prescribed instructions, not to exceed the current school year.

***Medication must be supplied to the school in the original container***

\_\_\_\_\_  
Parent/ Guardian's Signature

\_\_\_\_\_  
Date of Signature

\_\_\_\_\_  
Phone Number: Home/Work (indicate area code)

**WHITE:** Keep with medication (school copy)

**YELLOW:** Nurse