## Authorization for Administration of Medication at School

Student_____ Birthdate_____ Grade_____

---

**This form should not be used to prescribe emergency medications or injections**

**ONLY ONE MEDICATION PER FORM**

**Medication will be administered by trained designated school personnel to a student at school only when absolutely necessary per RCW 28A.210.260-270 and RCW 18.71.030 (3). Global Community Institute/Explorations Academy accepts no responsibility for unanticipated reactions when the medication is administered in accordance with the directions of the student's health care provider. Orders must be non-discretionary and legible.**

**THIS PORTION TO BE COMPLETED BY A LICENSED HEALTH CARE PROFESSIONAL (LHCP) PRESCRIBING WITHIN THE SCOPE OF THEIR PRESCRIPTIVE AUTHORITY**

(Please clearly print legible instructions)

Name of Medication Dosage _____

Diagnosis or reason for medication _____

Tablet/Capsule Liquid Inhaler Nebulizer Other _____

I request and authorize 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).

There exists a valid health reason which may make administration of the medication advisable during school hours.
If medicine is to be given WHEN NEEDED, describe indications_____
If medicine is to be given WHEN NEEDED, specify the minimum length of time between doses: _____

Possible medication side effects:_____

Emergency procedure in case of serious side effects:_____

I request and authorize this student to carry their medication. ☐Yes____LCP initials ☐ No ____LCP initials

I request and authorize this student to self-administer their medication. ☐Yes____LCP initials ☐ No ____LCP initials
☐ This student has been instructed and has demonstrated the ability to properly manage self-administration of medication.

If yes, I have trained this student in the purpose and appropriate method and frequency of use. ____LCP initials

Permission to carry: INHALER: ☐Yes____LCP initials ☐ No ____LCP initials ☐Yes____LCP initials ☐ No ____LCP initials

In situations where the parent, licensed health professional believe that it is in the best interest of the student that he or she carry medication, the student shall carry written permission from the parent indicating the name and dosage of the medication and the dates and times to be taken.

Date of Signature _____Licensed Health Professional (LHP)_____

Name (please print)_____ Telephone Number_____

**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 designated school staff permission to communicate with the health care professional about this medication. I understand oral medications may be administered by non-licensed staff members who have been trained by a Registered Nurse, Licensed Physician or Nurse Practitioner. Medication information may be shared with school staff working with my child, and 911 staff if they are called. All medication supplied must be brought to school in its original container with instructions as noted above by the licensed health care 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)

I certify that I am the parent, legal guardian, or other person in legal control of this student. I request and authorize the school to administer the medication prescribed, as authorized by TCW 28.A210.260-2070 and RCW 18.71.030(3). This includes oral, inhaled, topical, nasal, rectal, eye and ear drops that shall be given at school **only when absolutely necessary.** Designated/trained school staff shall administer this medication in compliance with Licensed Health Care Provider orders.

I understand the medication must be provided in the **current, original container** from the pharmacy with the student's name, the name of the medication and the amount to be given. Non-prescription medication must be furnished in the original container from the manufacturer. All medication must be in a form ready to be administered and **must not** require any preparation by school staff. If the dosage or time should change, new orders and container will be provided.

I understand it is **my** responsibility to deliver and maintain an adequate supply of the medication at school.

I understand medication orders are only valid for the current school year. Any medication remaining at the end of the school year, or not picked up immediately after the last day of school, will be disposed of.

Student may only carry a **one day supply** of oral medication (unless otherwise required on multi-day field trip).

Student agrees to take all medications as they are prescribed and will not independently make changes without the advice or direction of the prescriber.

1. I/We agree to inform the school immediately when changes are made to the current status of medications in use via the Medication/Update/Change Form (available upon request).

2. I/We agree to provide a specific plan describing how the student will carry his/her medication(s) at school and in the field; for example, what the medication(s) will be carried in and where they will be kept, as well as where an extra day supply will be stored. Medication(s) (one-day supply) can be locked up at the school if in an official pharmacy bottle.

_____ _____

Parent/Guardian Signature Date

_____

Parent/Guardian (Printed name)