WAHKIAKUM SCHOOL DISTRICT

500 S 3rd St., B398
Cathlamet, WA 98612

Medication in School Authorization Form School: School Year:

Wahkiakum Public Schools recognizes that in certain infrequent cases, students must take medication at school. When a health condition requires that a student be given prescription or non-prescription (over-the-counter) medication during school hours; authorization must be given by the child's parent or legal guardian and accompanied by written instructions and the signature of the prescribing licensed healthcare provider or dentist. The authorization must contain inclusive dates for each medication and any changes in the dosage or administrative instructions as they occur. Only medication in containers properly labeled by the licensed health care provider, dentist, pharmacist or manufacturer and brought to school by the parent or legal guardian will be accepted for administration by the school. Only school district personnel trained and delegated by the School Nurse are authorized to administer medication at school.

THIS SECTION TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDER OR DENTIST

Student's Name:_____ Date of Birth:_____

Reason for Medication: _____

Name of Medication:_____ Dose_____ Time/Frequency:_____

O Tablet/Capsule O Liquid O Inhaler O Epi-Pen O Injection O Other

For PRN Medication indicate frequency:_____ Symptoms _____

Medication may be repeated when and if:_____

Special Instructions for Administration:_____

Relevant side effects of medication: O None expected O Yes, please explain: _____

I authorize _____ that be administered the identified medication in accordance with the above stated instructions. There exists a valid health reason, which makes administering of this medication advisable during such time as the student is under the supervision of school officials.

O **It is medically necessary for student to carry the above medication (except controlled substances) in single-dose on their person. Student has been trained by health care provider to self-administer medication and is safe to self-administer medication.**

_____ _____ Date: _____

Signature of Licensed Health Care Provider/Dentist Name (Print or Type)

PARENT/GUARDIAN AUTHORIZATION

As parent/guardian of _____, I request designated school personnel to administer the medication as prescribed by the above prescriber. In the event the student is authorized to carry and self-administer an emergency medication and is unable to do so, I authorize school personnel to administer the medication as prescribed for student. I agree to provide back-up medication at school. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I understand and agree to comply with the district Medication Policy and Procedures. I authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature: _____ Date:_____

For School District Use Only

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self carry/self administration of emergency medication may be authorized by the prescriber and must be approved by the school nurse according to the RCW 28A.210.260, Public and Private Schools-Administration of Oral Medications by-Conditions.

O Yes O No Prescriber's authorization for self carry/self administration of medication signed above.

O Yes O No School RN approval for self carry/self administration of medication.

Reviewed by School Nurse:_____ Date: _____

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