# LaCenter School District

P.O. Box 1840, 725 Highland Rd. LaCenter, Wa. 98629

## Authorization For Administration Of Medication

(Oral medications, Inhalers, Epi-pens, Insulin, Eye, Ear, and Topical Medications)

For Questions contact the school nurse at:
Phone 360-263-2134 ext.218, Fax 360-263-2133

Student Name: _____ Birth Date: _____ Sex: M / F

School:_____Teacher:_____ Grade: _____

## **HEALTH CARE PROVIDER** completes this section: (please print)

I have determined that the medication named below is necessary during the school day.

Diagnosis or reason for medication:_____

Name of medication: _____ Dose:_____

☐ Tablet/Capsule ☐ Liquid ☐ Inhaler ☐ Nebulizer ☐ Other_____

If medicine is given DAILY, at what time? _____

If medicine is to be given WHEN NEEDED, describe indications: _____

_____

How soon can it be repeated?_____

*Is child allowed to carry and self-administer rescue inhaler ?* ☐ *Yes* ☐ *No*
*I have trained this student in the purpose and appropriate method and frequency of use.* *Yes*☐ *No* ☐
*Medication authorization are only valid for current school year.*

Significant side effects: _____

Date:_____ Health Care Provider Signature: _____

Phone #: _____ Print Name: _____

Fax #: _____ Address: _____

## **PARENT/GUARDIAN** completes this section:

I request that my child be allowed to take the medication as described above.
I request that authorized school staff assist my child in taking the medication(s) described above.
I understand that school staff will attempt to administer medication in a timely manner.
I will provide the medication in the original, properly labeled container.
I give my permission for the exchange of information regarding this medication between the school staff and health care provider. I authorize my student to self-carry inhaler/medication. Yes_____ No_____.

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| (Date) | (Parent/Guardian Signature) | (Daytime Phone) | (Emergency Phone) |

(OVER)

# SCHOOL MEDICATION POLICY

Whenever possible we encourage medication doses to be scheduled during non-school hours.

For those students who need medication at school, the following is required by Washington State Law (RCW 28A.210.260 and 270) and must be completed and on file **BEFORE** any medication may be given.

OVER-THE-COUNTER and NON-PRESCRIPTION MEDICATIONS/PRODUCTS

- Authorization for Administration of Medications Form **completed by both parent/guardian AND a licensed health care professional with prescriptive authority**.
- MUST be in original container labeled with the student's name.

PRESCRIBED MEDICATION

- Authorization for Administration of Medications Form **completed by both parent/guardian AND a licensed health care professional with prescriptive authority**.
- Medication must be in a properly labeled container from the dispensing pharmacy. A pharmacy can provide a labeled container for school upon request.
    - Student's name
    - Name, Strength and Dose of Medication
    - Time and Mode of Administration
- Provide no more than a 20 day supply.

PLEASE NOTE:

- Requests for the administration of oral medication are valid only for the medication listed and the dates indicated. Requests for medication administration must be re-authorized each school year.

- **All medications will be kept in the school office unless otherwise directed by the Health Care Provider. Medications stored in this area may not be available to the student during non-school hours.**
- **It is the responsibility of the parents/guardians to assure that necessary emergency (rescue) medications are available to their students after school hours and while traveling to/from and during after school events.**

***Thank you for your cooperation.***