Edmonds School District

HS 500
Student Health Services
Authorization for Administration of Medication in School

Student's Name:_____ Birthdate: _____

School: _____ Grade: _____

Medication is ordered to be given to a student at school only when absolutely necessary.

This Portion to be Completed by the Licensed Health Care Professional (LHCP)
(e.g., MD, DO, ARNP, DDS, etc.)

Diagnosis	Medication	Dosage	Route	Time/Interval Condition/Symptom	Self-Carry*	Side Effects
					Y N	
					Y N	
					Y N	
					Y N	
					Y N	
					Y N	

***Marking "yes" to self-carrying indicates that the LHCP has provided instruction in the purpose and appropriate method/frequency of use, and that the student is capable and safe to self-carry and administer.**

I request and authorize that the above-named student receive the above identified medications in accordance with the instructions indicated beginning ____/____/____ to not to exceed current school year OR ____/____/____.

LCHP's Signature:_____ Date:_____

LCHP's Name: _____ Phone Number: (_____)_____

LCHP's Address: _____ Fax Number: (_____) _____

SECTION CAN ONLY BE COMPLETED BY A HEALTH CARE PROVIDER WITH PRESCRIPTIVE AUTHORITY

Give scheduled medication to student on Early Release days. Y□ N□

Parent/Guardian Permission

The medication is to be furnished by me in the original container, labeled by the pharmacy with the name of the medicine, amount to be taken, and the time of day to be taken. The Licensed Health Professional's name is on the label. If medication remains after the course of treatment, I will collect the medication from the school or understand that it will be destroyed.

Signature of Parent/Guardian: _____ Date: _____

Student Signature (Self-Carrying):_____ Date: _____

Nurse Signature: _____ Date: _____

TURN OVER TO COMPLETE FORM

Administration of Medication in School

Medication should be given at school only when necessary. If the student must receive prescribed or non-prescribed oral or topical medication, eye drops, ear drops, or pre-mixed nasal spray medications during school hours or when the student is under the supervision of school officials, the principal and the school nurse will designate and train staff for dispensing medications. The medication to be given at school must have a written order signed by a Licensed Health Care Professional (LHCP) working within the scope of their prescriptive authority and have a parent/guardian signature. The medication must be in the original, properly labeled container. This includes any over

THIS PORTION TO BE COMPLETED BY PARENT/GUARDIAN

I the Parent/Guardian Understands:

- When notified by school personnel that medication remains after the course of treatment I will collect the medication from the school or understand that it will be destroyed.
- Edmonds School District #15 assumes no responsibility for self-carried medications.
- In the event a safety issue arises, the school nurse has the right to notify the parent/guardian/student and discontinue the self-medication privilege. Students health plan will be modified to reflect current needs.
- I will provide the medication in a properly labeled container.
- This authorization is only good for one school year with the exception of self-carry medications.

Optional: □ By checking this box I hereby give consent to have non-controlled medication returned home with student.

My signature below indicates that I have read and understand and will abide by the medication policy.

Signature of Parent/Guardian: _____Date: _____

Student Signature (Self-Carrying):_____Date:_____