AUTHORIZATION FOR MEDICATION

Northshore
School District
3416 F-1

The following section is to be completed by the PARENT/GUARDIAN: (please print)

Student's Name:_____ Birth Date:_____ Sex: M ☐ F ☐

School: _____ Grade:_____

Health Care Provider (HCP): Name:_____

Address:_____ Phone:_____ Fax:_____

⇒ I request that my child be assisted by authorized personnel in taking the medication prescribed below at school, or be permitted to self-medicate according to Heath Care Provider (HCP) instructions and School District Policy 3416

⇒ I understand that my signature on this form constitutes a waiver by me to the school district and authorized supervising personnel for liability for adverse reaction when medication is administered in the proper manner.

⇒ Changes to the time and/or dose of medication require written authorization from the HCP and Parent/guardian.

⇒ I understand that a medication dosage could be delayed or missed due to unexpected circumstances or changes in the student's schedule. If I am unable to accept this condition the district is not obligated to honor the request for administration of medication by school staff.

⇒ **Medication must be provided to the school in a properly labeled prescription bottle or the original over-the-counter container. Ask the pharmacist to supply a second prescription bottle for school use.**

⇒ I give permission for exchange of information between the school and HCP.

_____ _____ _____ _____
Parent/Guardian Signature | Date | Home Phone | Emergency Phone

☐ I request permission for my child to **self-carry medication for asthma or anaphylaxis during any school-sponsored activities occurring before/after school or overnight outdoor education programs**.

☐ I request permission for my child to **self-administer medication for asthma or anaphylaxis**. By law my signature indicates that I understand the district shall incur no liability as a result of any injury arising from the self-administration of medication by the student and parents or guardians shall hold harmless the district and its employees or agents against any claim arising out of the self-administration of medication by the student (3419).

_____
Parent/Guardian Signature

The following section is to be completed by the HEALTH CARE PROVIDER: (please print)

Diagnosis or reason for medication:_____

	Name of Medication	**Dose**	**Route**	**Time/Frequency**
#1				
#2				
#3				

If medication is to be given AS NEEDED, describe instruction:_____

_____

Significant side effects:_____

Is child authorized to carry and self-medicate? Yes ☐ No ☐

If yes, for asthma and anaphylaxis medication, I have trained this student in the proper Administration and Frequency of use.

If ordered and the School Nurse is NOT AVAILABLE (e.g. field trip, after school activity etc.):

***Epinephrine Auto-injector WILL be given for ANY allergy symptoms or known ingestion.**

***Glucagon, Midazolam and Diastat WILL NOT be administered by other school staff, 911 will be called.**

Start Date: _____ Discontinue Date:_____ **or** end of school year ☐

_____ _____ _____
Health Care Provider Signature | Date | Phone

Return to: _____ _____ _____
School Nurse | Phone # | Fax #

School Address: _____

NORTHSHORE SCHOOL DISTRICT

MEDICATION GUIDELINES

If your student will be taking ANY medication at school, you must confer with the school nurse.

The Northshore School District recommends that medication be taken at home whenever possible. We recognize, however, that in some cases it is essential that medication be administered during the school day. For the protection of all the students and to comply with Washington state law, the district has a policy and procedures in place for the handling of ALL medications in the schools.

Please do not put any kind of medicine, including aspirin, vitamins, and cough drops in your child's lunch box, backpack or pockets. Unidentified medicine can **never** be given at school.

School Staff Administered - The following conditions must be met:

- √ All medications, whether over-the-counter or prescription, need a current Northshore Medication Authorization Form signed by the student's Health Care Provider/dentist **and** parent/guardian.
- √ Medication must be delivered to school in a properly labeled prescription or original over-the-counter container. The student's name must be on the label with proper identification of the drug, dosage, and directions for administration.
- √ A quantity sufficient for one month **only** can be sent to school.
- √ The medication order is effective for the **current** school year only.
- √ If changes in the medication order occur, the parent is responsible for notifying the school and providing verification from the Health Care Provider/dentist.

Field Trips: For students on daily medication, request an extra labeled empty bottle from your pharmacy that can be used for field trips.

Student Self-Administered Medication - The following conditions must be met:

In appropriate cases and with the knowledge of the school nurse, the parent/guardian can delegate the responsibility for self-administration of medication to the student. In doing so, the parent releases the school district from any obligation to monitor the student and assumes full responsibility for the student's use of the medication.

- √ Self-Administration does not apply to controlled substances, e.g. codeine, vicodin
- √ The student may only carry a one-day supply (1 - 2 doses) of the medication.
- √ The medication must be in the original container.
- √ The student must have written permission to self-medicate signed by the parent/guardian.

Medication to be self-administered for more than fifteen (15) consecutive days whether over-the-counter or prescription requires a current Northshore Medication Authorization Form signed by the student's Health Care Provider/dentist and parent/guardian stating that the student may self-medicate. The student must also demonstrate his/her ability to the School Nurse to correctly evaluate his/her symptoms and use the medication appropriately.

Asthma and Anaphylaxis medications:
When a parent requests that his/her student be allowed to self-administer medication for asthma and/or anaphylaxis (severe allergic reaction), a Medication Authorization Form must be filled out and signed by the Health Care Provider **and** parent/guardian. The permission form must contain a treatment plan for what to do in case of an emergency.
The Health Care Provider must also provide training for the student to recognize symptoms and the correct use of medications. Additionally the student must demonstrate his/her ability to correctly evaluate his/her symptoms and use of medications to the school nurse including how to access help when needed. (RCW 28A.210.370 and School District Policy 3419)