



# AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Birth Date: \_\_\_\_\_

School: \_\_\_\_\_ Teacher: \_\_\_\_\_ Gender: \_\_\_\_\_

**HEALTH CARE PROVIDER** with prescriptive authority completes this section: (please print)

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

**Diagnosis for which medication is given:** \_\_\_\_\_

Yes  No This is a LIFE THREATENING condition for this student that requires medication and a nursing care plan at school prior to the student attending school safely per RCW 28A.210.320.

**Name of Medication:** \_\_\_\_\_ **Route:** \_\_\_\_\_

**Dose:** \_\_\_\_\_ **Strength if variable:** \_\_\_\_\_

**If medicine is given DAILY, at what time:** \_\_\_\_\_

**If medicine is given WHEN NEEDED, describe indications:** \_\_\_\_\_

**May repeat in:** \_\_\_\_\_ minutes / hours, as needed

- Store medication in school clinic with school staff to administer. (If no box checked, this option is the default.)
- The student is authorized to self-administer the medication. By checking this box, the Health Care Provider represents that they trained the student to self-administer the medication and that the medication is safe to self-administer.

**Duration:**  Current school year  Other: \_\_\_\_\_

**Possible side effects:** \_\_\_\_\_

**Emergency procedures in the event of serious side effects:** \_\_\_\_\_

**Conditions when medication should not be given:** \_\_\_\_\_

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Phone #: \_\_\_\_\_ Print Name: \_\_\_\_\_

Fax #: \_\_\_\_\_ Address: \_\_\_\_\_

**PARENT/GUARDIAN/ELIGIBLE STUDENT** completes this section:

**Check One Box:**

- I request that authorized school personnel assist my child to take the medicine(s) described above.
- I request that my child be permitted to self-administer the medicine(s) described above. I will hold harmless and indemnify the District, its officers, employees, and personnel against all claims or liability arising out of the student's self-administration or carrying of medication.
- I am at least 18 years old and sign this form on my own behalf (RCW 26.28.015 or RCW 70.02.130). I give my permission for the exchange of information between the school staff and health care provider.

My signature indicates my permission for the exchange of information between the school staff and health care provider and my understanding that the District and school staff will not incur any liability for any injury when the medication is administered in accordance with the health care provider's direction and Washington law.

\_\_\_\_\_ Date

\_\_\_\_\_ **Parent/Guardian/Eligible Student Signature**

\_\_\_\_\_ Phone Number(s)

E-mail address: \_\_\_\_\_

## AUTHORIZATION FOR ADMINISTRATION OF MEDICATION (cont.)

Whenever possible, students should receive medications during non-school hours. For those students who need medication at school, the following is required by Washington State law and must be completed and on file **BEFORE** any medication may be given at school:

- All medications (including over-the-counter) to be administered at school require an authorized signature of both the Parent/Guardian/Eligible Student and a Licensed Healthcare Professional.
- Over-the-counter medication must be in original store packaging.
- Prescription medications must be properly labeled in their original pharmacy container and must include the:
  - Student's name
  - Name and strength of the medication, including dosage to be given
  - Time and method of administration
  - Length of time/Days to be given
- Trained unlicensed school staff may only administer medications orally, through the ear or eye, or topically. Epinephrine auto-injectors (i.e., Epi-Pen, Auvi-Q) are an exception. All other injectable medications and rectal medications may be administered only by a licensed nurse. Please contact your school nurse for more information.

### PLEASE NOTE:

- Please review the Renton School District's Medication Policy and Procedure 3416 and Self-Administration of Asthma and Anaphylaxis Medication Policy and Procedure 3419.
- Requests for medication administration are valid only for the medication listed and for the duration indicated.
- Requests for medication administration must be re-authorized each school year.
- If medication remains at school after the course of treatment, the parent/guardian/eligible student will collect the medication from school or understand that it will be destroyed.
- If the student self-carries and self-administers the medication, it is recommended that families provide back-up medication to be stored by the district.
- Medications will be stored in the school office/health clinic unless otherwise directed by the Health Care Provider. Medications stored in this area will be unavailable 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.
- Permission to possess and self-administer medication may be revoked by the principal or school nurse if it is determined that the student is not safely and effectively carrying and self-administering medication.
- The district endeavors to maintain consistent and safe medication storage temperatures while medication is at school. This cannot be guaranteed. The district cannot provide replacement medication due to power failures or acts of nature.

*Thank you for your cooperation.*