Waiver and Authorization to Administer Medication

Student Name: _____ Gender: M / F Date of Birth:_____ Grade:____ Campus: _____

I give my permission for exchange of information between The Bear Creek School and the licensed health care provider listed below.

Date _____ Parent Signature _____

Oral Medications

Pursuant to RCW 28.A.210.260 and RCW 28A.210.270, The Bear Creek School is authorized to administer oral medication to students during school hours. Such medications will only be administered when the failure to receive the medication may result in the student being unable to attend school and/or not being well enough to participate in learning activities. Medication is defined as all drugs, whether **prescription** or **over-the-counter.**

The administration of any oral medication to a student must be requested and authorized in writing by a parent or legal guardian and a licensed health care provider with prescribing authority acting within the scope of his/her license. Specific instructions for administration must be included.

Middle School and Upper School students may self-administer prescription medication when authorized by the parent and **licensed health care professional** and approved by the school nurse. *All medication must be stored in the health room*.

Middle School and Upper School students may self-administer over-the-counter medication when authorized by the parent and school nurse. *All medication must be stored in the health room*.

Requests for the administration of oral medication are valid only for the medication listed and the dates indicated in writing on the request form, and in no case will such requests exceed one school year. Any request for administration during a subsequent school year shall require the request to be re-authorized.

Non-Oral Medications

Medication administered by routes other than oral, for example: ointments, eye drops, nasal inhalers, suppositories, or non-emergency injections, may not be administered by school staff other than registered nurses. Epinephrine is the only injectable that school staff are trained to administer to a student who has a predetermined, life-endangering allergy.

This portion to be completed by the Licensed Health Care Provider

Name of Medication	Dosage	Time of Day to be Taken

List any known medication allergies _____

Diagnosis or reason for medication _____

If given PRN, specify the length of time between doses _____

Middle School/Upper School student may self-administer medication ☐ Yes ☐ No

Possible side effect of medication _____

I/We request/authorize the school to administer or allow self-administration of the above medication to the above student in accordance with the instructions indicated above for the period from _____ to _____ (not to exceed current school year).
Special instructions _____

Duration of order if less than current school year_____

Licensed Health Care Provider/Physician/Dentist Signature _____ Date _____

Print Name _____ Phone _____ Fax _____

Physician Address _____

Note to parents

All medication to be administered by school staff must be:

- Brought to school by the parent
- In the original container, labeled with the student's name, name of the medication, dosage, mode of administration, and name of the health care provider.
- Not more than a one-month supply (unless it is an emergency medication, such as epinephrine or inhaler). **(OVER)**

Student Name: _____ Gender: M / F Date of Birth:_____ Grade:____ Campus: _____

- Unexpired.
- Stored in the health room. A second set of emergency medications (epinephrine, inhaler, or insulin) should be provided—for either the Lower School classroom or the Middle School/Upper School student's binder.

All medication to be self-administered by the student must be:

- In the original container, labeled with the student's name, name of the medication, dosage, mode of administration, and name of the health care provider (for prescription medication).
- Not more than one monthly dose in the original container.
- Stored in the health room.

This portion to be completed by the Parent/Guardian

Name of Medication	Dosage	Time of Day to be Taken	Person to Administer (self / staff / either)

List any known medication allergies _____

Diagnosis or reason for medication _____

Other medication the student is taking _____

Middle School/Upper School student may self-administer medication ☐ Yes ☐ No

Possible side effect of medication _____

For student self-administration: I/We certify that I/we am/are the parent/legal guardian of the above named student. I/We authorize my/our child/ward to self-administer medication as specified. I/We shall hold harmless and indemnify The Bear Creek School's officers, employees, and agents against all claims, judgments, or liabilities arising out of the self-administration of medication as described.

For staff administration: I/We request/authorize the school to administer the above medication to the above identified student in accordance with the licensed health care provider's instructions for the period from _____ to _____ (not to exceed current school year). I/We understand that every effort will be made by the school staff to administer the medication in a timely manner.

Print Name _____ Parent Signature _____ Date _____

Home Phone_____ Work _____ Cell _____

Print Name _____ Parent Signature _____ Date _____

Home Phone_____ Work _____ Cell _____

School Nurse Approval _____ Date _____

Approval of Parent/Guardian and Limitation of Liability

I/We hereby authorize The Bear Creek School personnel to administer and/or for my/our child/ward to self-administer the medication identified above to be taken at school as ordered by the student's physician/dentist or at my/our direction. I/We understand that my/our signature(s) on this form constitute(s) a waiver of liability by me/us to The Bear Creek School and authorized personnel, as may arise from the administration of medication at school. I/We request that authorized personnel administer medications to my/our child/ward as described above at school, or that my/our child/ward be permitted to self-medicate in the presence of authorized personnel. I/We realize that my/our child/ward must take responsibility to go to the office to request the medication. As time and dosage adjustment may occur, authorized personnel will follow the doctor's recommended changes upon written notification from the parent/guardian. All medication must be unexpired, in the original container, and label must include the student's name, name of the medication, dosage and dosing schedule, mode of administration, and name of physician. (Please ask pharmacist for an additional labeled container for school use.) **All epinephrine must be supplied by the parent/guardian and be in the original container. The label must include the student's name, name of the medication, dosage and dosing schedule, mode of administration, and name of physician. The School requires emergency medications be kept in both the health room *and* classroom or in the case of Middle School/Upper School in the student's binder.**

I/We hereby acknowledge that I/we read and understand English and have read and understand the terms and conditions set forth in this waiver and authorization form. Alternatively, I/we hereby acknowledge that if I/we do not read and understand English that I/we have consulted with someone who does and such person has fully explained the terms and conditions set forth in this waiver and authorization form. I/We fully understand the terms and conditions set forth in this waiver and authorization form.

Parent/Guardian Signature _____Date_____

Print Name _____

Parent/Guardian Signature_____Date_____

Print Name _____