

BELLEVUE CHRISTIAN SCHOOL STUDENT SELF-MEDICATION AUTHORIZATION FORM

STUDENTS MAY NOT CARRY OR SELF-ADMINISTER MEDICATION AT SCHOOL UNTIL THIS FORM IS COMPLETED, RETURNED TO SCHOOL, AND APPROVED BY A SCHOOL PRINCIPAL OR SCHOOL NURSE.

It is strongly recommended that medications be stored and administered by school personnel as provided by RCW 28A.210.260. You may request this service by completing a Medication Authorization Form. Parents who wish their child to carry and self-administer oral medications at school must obtain authorization from a dentist or physician and sign the Parent/Guardian Request below. This authorization created by this request shall not extend past the end of the current school year.

Requests will be valid only for the medication(s) listed and the dates indicated on this written request form. Medications must be supplied in the original container including the label showing the student's name, the health care provider's name, the name of the medication, dosage, and instructions for administration. Over-the-counter medications such as aspirin and antihistamines must be carried in the original retail container.

STUDENT NAME:		
Parent/Guardian Name:	Home Phone:	Work Phone:
	MEDICATION #1	MEDICATION #2
Medication name and strength:		
Dosage (number pills/tsp):		
Time of administration:		
Reason for administration:		
Potential Side Effects:		
Date medication is to begin:		
Date medication is to end:		
Other medications being taken:		

I request and authorize the self-administration of the above medication(s) for the time period shown, as there exists a valid health reason which makes administration of the medication necessary during school hours.		
Physician/Dentist Signature	Type or Print Name	Date
		Phone

PARENT/GUARDIAN REQUEST	
I certify that I am the parent, legal guardian, or person in legal control of the above-named student. Upon the advice of my child's physician, I authorize my child to carry and self-administer oral medication as specified above. I shall hold harmless and indemnify the Bellevue Christian School's officers, employees, and agents against all claims, judgments, or liabilities arising out of the administration of medication as described above. I also authorize the School to enter into a Mutual Exchange of Information with the student's physician or dentist named above.	
Parent/Guardian Signature:	Date:

Principal Approval:	Date:
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