Authorization for Administration of Medication at High School

TO: Parent/Legal Guardian, Licensed Health Care Provider

RE: Administration of medication at High School

Pursuant to RCW 28A.210.260 and RCW 28A.210.270, the Issaquah School District is authorized to administer medication (prescribed or over-the-counter oral or topical medication, eye drops or ear drops) to students during school hours. It is district policy that 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. The district policy defines medication to mean all drugs, whether prescription or over the counter.

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

High School students may be allowed to carry and self-administer **prescription medication** when authorized by the parent and licensed health care professional and approved by the school nurse and principal.

High School students may be allowed to carry and self-administer **over the counter medication** when authorized by the parent, school nurse and principal.

Requests for the administration of 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.

Each school principal will authorize two (2) staff members to administer prescribed or over-the-counter non-prescribed oral or topical medication, eye drops or ear drops. Oral medications are administered by mouth either by swallowing or by inhaling and may include administration by mask if the mask covers the mouth or mouth and nose. . Epi-Pen and Epi-Pen Jr. are the only injectibles that school staff will be trained to administer to a student who is susceptible to a predetermined, life-endangering situation.

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.

All medication to be carried and 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 daily dose in the original container.

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Student Name: _____ Birth Date: _____

School: _____ Grade: _____

I give my permission for exchange of information between the school district staff and the licensed health provider.

Date: _____ Parent Signature: _____

THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH CARE PROVIDER

Name of Medication	Dosage	Time of Day to Be Taken

Diagnosis or reason for medication: _____

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

Student may carry and self-administer medication: YES ☐ NO ☐

Possible side effects of medication: _____

I 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 _____

Licensed Health Care Provider Signature: _____ Date: _____

Telephone Number: _____ Fax Number: _____

Name (Print) _____

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

Name of Medication	Dosage	Administration Time	Person to Administer/Self/Staff/Either

Diagnosis or reason for medication: _____

Other medication the student is taking: _____

Student may carry and self-administer medication: YES ☐ NO ☐

For student self-administration; I certify that I am the parent/legal guardian of the above named student. I authorize my child to carry and self-administer medication as specified. I shall hold harmless and indemnify the Issaquah School District'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 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 current school year.
I understand that every effort will be made by the school staff to administer the medication in a timely manner.

Parent Signature: _____ Date: _____
Telephone Home: _____ Work: _____ Cell: _____
School Nurse approval: _____ Date: _____
Principal approval for student to carry and self-administer medication: _____
Date: 09.24.86; 05.12.93; 06.26.96; 07.15.03; 06.02.06; 12.10.12