Authorization for Administration of Medication at Elementary and Middle School

TO: Parents/Legal Guardian, and Licensed Health Care Provider

RE: Administration of medication at Elementary and Middle 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 acting within the scope of his/her license. Specific instructions for administration must be included.

Students may carry and self-administer medication for emergency health reasons when requested by the parent and licensed health care provider and approved by the school nurse and the 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 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 (for prescription medication).
- Not more than a one month supply

On request, a pharmacist can provide an extra container—with the required information at the time the prescription is filled.

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The following section is to be completed by the PARENT/GUARDIAN

(please print)

Student's Name: ______________________________ ______________________________ Sex: _________
Last First

School: ______________________ Grade:_________ Birthdate: _________________

Name of Medication: __________________________ Reason for taking it: ________________________

_________________________ _________________________ _________________________
Name of Physician/Health Care Provider Physician Phone # Physician Fax #

I request and authorize the school to administer the identified medication to the above student in accordance with the Health Provider's prescribed instructions, not to exceed the current school year. I give my permission for exchange of information between the School District staff and the Licensed Health Care Provider. I understand that the medication is to be furnished by me in the original container. For self-administration of inhaler or epi-pen, 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.

Date: ________________________Parent/Guardian Signature: ___________________________________

Home Phone: _________________Cell Phone: __________________Work Phone: _________________________

The following section is to be completed by the PHYSICIAN/HEALTH CARE PROVIDER

(please print)

Diagnosis for which medication is given: ____

Name of medicine: ____

Dosage, time and mode of administration: ____

If medicine is to be given AS NEEDED, describe indications: ______________________________

____

If medication is prescribed for a limited length of time, please write duration: _______________________

List significant side effects: ____

Other information: ____

For inhalers - Student is capable of carrying and self-administration ☐ YES ☐ NO

For Epi-pen/Epi-pen Junior - Student is capable of carrying and self-administration ☐ YES ☐ NO

*Checking yes indicates that student has been instructed in the purpose and appropriate method/frequency of use.

I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated. <u>Medication orders are good for the current school year, unless a shorter period is specified.</u> There exists a valid health reason which makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials.

Health Care Provider's Signature: ____

Health Care Provider's Printed Name: ____

Date:_________________________ Phone #: ____________________________ Fax #: ______________________

School Nurse Approval: ____________________________________ Date: ________________

Principal notified if student is self-carrying medication: ______________________________________

Date: 09.24.86; 05.12.93; 06.26.96; 07.15.03; 06.02.06; 12.10.12