Issaquah School District #411 Disaster Planning Authorization for the Administration of Medication for 72 hours at School

TO: Parent/Legal Guardian, Licensed Health Care Provider

RE: Disaster Planning: Administration of Medication for 72 hours at School

In the event of a major disaster such as a severe earthquake, schools may be responsible for the care of their students for as much as 72 consecutive hours. With this in mind, it is important to consider those students who require daily medication for their health and well being.

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. 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 <u>and</u> a licensed health care provider acting within the scope of his/her license. Specific instructions for administration must be included.

All medication provided by parents must be in the original container.

The label must include:

- 1. the student's name
- 2. name of medication
- 3. daily dosage
- 4. mode of administration
- 5. name of the licensed health care provider

Requests for administration of medication during a disaster are valid for one academic year only.

Form: 3416F7

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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 care provider.		
Date:Parent/Guardian Signature:		
THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH CARE PROVIDER		
Name of Medication	<u>Dosage</u>	<u>Time of Day To Be Taken</u>
Diagnosis or reason for medication:		
Diagnosis or reason for medication: For inhalers student is capable self-administration: YES NO		
Possible side effects of medication:		
Additional Instructions:		
I request/authorize the school to administer the above medication to the above identified student in accordance with the instructions indicated above for the period from		
Licensed Health Care Provider Signature: _		
Telephone Number:		
Print Name:		
THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN		
Name of Medication	<u>Dosage</u>	Time of Day To Be Taken
Diagnosis or reason for medication:		
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 period from to (not to exceed current school year).		
Parent/Guardian Signature:		Date:
Telephone Number: (Home)		
School Nurse approval:		

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