Dieringer School District #343
1320-178th Ave. E.
Lake Tapps, WA 98391
Lake Tapps Elementary School: Phone 253-862-6600; Fax 253-862-3176
Dieringer Heights Elementary School: Phone 253-826-4937; Fax 253-826-4908
North Tapps Middle School: Phone 253-862-2776; Fax 253-862-2587

Authorization for Administration of Medication at School

Student Name: ____ Birth date: _______________________

School: __________________________ Teacher/Grade: _______________________________________

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THIS PORTION TO BE COMPLETED BY LICENSED HEALTH PROFESSIONAL WITH PRESCRIPTIVE AUTHORITY

Name of Medication: ______________________ Strength: ___________Dosage: ___________________

Method of Administration: __________________ Time of Day to be given: _________________________

If to be given as needed (prn), specify minimum length of time between doses: ______________________

Diagnosis: ____

May student carry inhaler on his/her person? ** Yes _______ No __________
****This student has demonstrated to a licensed health professional in my office the ability to correctly administer this medication*****

Is student trained to self-administer emergency injectable medicine? Yes ________ No _________

Possible side effects of medication: ____

Emergency procedure in case of serious side effects: ____

I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated above from ____________ to _________(not to exceed the current school year). There is a valid reason which makes the administration of this medication necessary during school hours.

Date of Signature: ___________Signature: ____

Telephone #: _______________ Fax #: ______________Print Name: ___________________________________

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THIS PORTION IS TO BE COMPLETED BY A PARENT/GUARDIAN

I request and authorize the Dieringer School District to administer the above ordered medication for my student in accordance the directions given from __________________ to ________________ (not to exceed the current school year). Prescription medication will be supplied to the school in the original container with the pharmacy label attached which includes the student's name, medication, dosage and time to be given.
I will allow my student to carry their own inhaler: Yes____ No ____
My student is trained to self-administer their own emergency injectable medication. Yes _____ No_____

I agree that the Dieringer School District shall incur no liability as a result of any injury arising from the self administration of medication by my child. I agree to hold harmless the district and its employees or agents against any claims arising out of the self administration of medication by my child.

Date of Signature: ___________ Parent/Guardian Signature: _______________________Phone #:____________