EPHRATA SCHOOL DISTRICT ~ STUDENT HEALTH SERVICES

333 Fourth Avenue NW Ephrata, WA 98823 509.754.7233 or 509.754.7232 FAX 509.754.7266

Authorization for *MEDICATION* at School

Student's Name:		**Birth date**		**Grade:**	

THIS PORTION MUST BE COMPLETED BY THE LICENSED HEALTHCARE PROVIDER

Name of Medication	***Dosage***	***Route***	***Time of Day***	***Time Interval if PRN***

For short term inhaler treatment for respiratory infection: In my office, this student has demonstrated the ability to correctly self-administer this inhaler and may carry the inhaler on their person. YES ☐ NO ☐ N/A ☐

Reason for medication to be given during school hours: _____

Anticipated action: _____

Possible side effects and needed response if side effects occur: _____

Known Allergies, including medication: _____

I request and authorize that the above named student be administered this medication according to the instructions indicated above from ___/___/___ to ___/___/___ or ☐ the entire current school year including summer months as there exists a valid health reason which makes the administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials. Such medication may be administered by medication trained school personnel.

Date: _____ Print Name: _____

Telephone #: _____

Office Fax #: _____ Signature: _____

Licensed Healthcare Provider Signature

THIS PORTION OF THE FORM IS TO BE COMPLETED BY THE PARENT / GUARDIAN

I certify that I am the parent, or legal guardian in legal control of the above identified student and request and authorize the school to administer the above identified medication to the above identified student in accordance with the prescription, or doctor's instructions, from ___/___/___ to ___/___/___ or ☐ the entire current school year including summer months.

I understand the district policy on administration of medication at school and I am in agreement to its content. Medication must be in the original container labeled with instructions on how it will be given at school. I understand that every effort will be made by school staff to administer the medication in a timely manner and accept that at times the doses of medication may be delayed or missed due to conflicts in student's schedule or other responsibilities of school personnel. I give my consent to release the above identified student for further medical or hospital care in the event of an emergency. I give my consent for School District staff to exchange information with the above health care provider and associated school staff regarding the above student for the duration of the school year.

_____ _____

Date Parent/Guardian Name
Please Print

_____

Home Work Cell Parent/Guardian Signature

EPHRATA SCHOOL DISTRICT ~ STUDENT HEALTH SERVICES

333 Fourth Avenue NW Ephrata, WA 98823 509.754.7233 or 509.754.7232 FAX 509.754.7266

Authorization for *MEDICATION* at School

Student's Name:		**Birth date**		**Grade:**	

THIS PORTION MUST BE COMPLETED BY THE LICENSED HEALTHCARE PROVIDER

Name of Medication	*Dosage*	*Route*	*Time of Day*	*Time Interval if PRN*

For short term inhaler treatment for respiratory infection: In my office, this student has demonstrated the ability to correctly self-administer this inhaler and may carry the inhaler on their person. YES ☐ NO ☐ N/A ☐

Reason for medication to be given during school hours: _____

Anticipated action: _____

Possible side effects and needed response if side effects occur: _____

Known Allergies, including medication: _____

I request and authorize that the above named student be administered this medication according to the instructions indicated above from ___/___/___ to ___/___/___ or ☐ the entire current school year including summer months as there exists a valid health reason which makes the administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials. Such medication may be administered by medication trained school personnel.

Date: _____ Print Name: _____

Telephone #: _____

Office Fax #: _____ Signature: _____

Licensed Healthcare Provider Signature

THIS PORTION OF THE FORM IS TO BE COMPLETED BY THE PARENT / GUARDIAN

Certifico que soy el padre/la madre o el tutor legal que tiene control legal del estudiante identificado anteriormente, y solicito y autorizo a la escuela que administre el medicamento identificado anteriormente al estudiante identificado anteriormente según la receta o las indicaciones del médico, durante el período de ___/___/___ a ___/___/___ o ☐ todo el año escolar actual, incluidos los meses de verano.

Entiendo la política del distrito con respecto a la administración de medicamentos en la escuela y estoy de acuerdo con su contenido. Los medicamentos deben estar en su recipiente original y deben tener una etiqueta con las instrucciones de cómo se administrará en la escuela. Entiendo que el personal de la escuela hará todo lo posible por administrar el medicamento en el momento debido y acepto que a veces las dosis del medicamento se pueden retrasar u omitir debido a conflictos con el horario del estudiante u otras responsabilidades del personal de la escuela. Doy mi consentimiento para permitir que el estudiante identificado anteriormente reciba atención médica u hospitalaria adicional en el caso de una emergencia. Doy mi consentimiento para que el personal del Distrito Escolar intercambie información con el proveedor de atención médica mencionado anteriormente y el personal de la escuela relacionado con respecto al estudiante identificado anteriormente durante el año escolar.

_____ _____

Fecha Nombre del padre / la madre / tutor

Favor de usar letra de imprenta

_____

Casa Trabajo Celular Firma del padre / la madre / tutor