FERNDALE PUBLIC SCHOOLS
Ferndale, Washington

AUTHORIZATION FOR SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION AT SCHOOL

STUDENT ______________________________ BIRTHDATE ____________________

SCHOOL ______________________________

THIS PORTION TO BE COMPLETED BY STUDENT'S PHYSICIAN OR DENTIST

Medication will be taken by a student at school only when absolutely necessary. Whenever possible, the parent and licensed health care provider are urged to design a schedule for giving medication outside of school hours.

Name of Medication: ______________________________

Strength of Tablets: ________mg. # of Tablets____________ Total Dosage ________________mgs.

Inhalers/Dosage ______________________________

Time(s) of Dosage: ______________________________

Anticipated action of Medication: ______________________________

Length of Prescription Period: From ____________________ To ____________________

Possible side effects: ______________________________

Emergency measures in case of serious side effects: ______________________________

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I certify that valid health reasons exist requiring that the student have oral medication during school hours or during such time that the student is under supervision of school officials.

I believe it is in the student's best interest to self-medicate and I authorize the above-named student to self-administer the above-identified medication in accordance with the instructions indicated.

______________________________ ______________________________
Date of Signature Licensed Health Care Provider's Signature

______________________________ ______________________________
Telephone Number NAME (Print or Type)

Parent/Guardian portion to be completed on back of form. **OVER** ⇒

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

I certify that I am the parent, legal guardian, or other person in legal control of the above-identified student and I have read this form. I believe it is in my child's best interest to self-medicate and I authorize him/her to self-administer, in accordance with the instructions indicated, the medication identified on this form by the licensed health care provider.

I have read this form and I understand that:

1. A written authorization form must be signed by the licensed health care provider and parent indicating the dosage of the medication and dates and times it is to be taken. A copy will be kept in the office and a copy should be carried by the student.

2. The medication must be furnished in an original container from the pharmacy with the student's name, the name of the medication and the amount to be given. Non-prescription medication must be furnished in the original container from the manufacturer. All medication must be in a form ready to be administered and must not require any preparation by building staff.

3. The student will carry only **one day's dosage** in an original labeled container.

4. The school will assume no responsibility or liability for the administration of the medication or recording how often it is used.

5. **Any violation of the Ferndale School District 3200 "illegal drugs, alcohol/tobacco" policy or the "medication" policy and procedures 3410 will result in corrective actions as outlined in the 3200 policy and procedures. A violation will also result in notification to the parent; licensed health care provider and self-administration privileges will be revoked.**

Parent/Guardian Signature: ________________________________Date: ____________________________

Telephone Number: ___________________________/ ____________________________
HOME WORK

THE COMPLETED FORM MUST BE RETURNED TO THE SCHOOL OFFICE PRIOR TO THE STUDENT BEGINNING SELF-MEDICATION.