

PERMISSION TO ADMINISTER MEDICATION AT SCHOOL

District: Grandview School	School: _____	Phone: _____ Fax: _____
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Student: _____ Birthdate: _____ Grade: _____

PARENT/GUARDIAN SECTION *SECCION DE PADRE/GUARDIAN

I request that the school nurse, or designated staff member, administer the medication prescribed below, in accordance with the healthcare provider instructions. I give my permission for the following medication information to be shared with school staff on a "need to know" basis. ☐yes ☐no

Yo pido que la enfermera o personal designado, le administre el medicamento recetado de acuerdo con las instrucciones del medico. Doy permiso que la siguiente informacion sea compartida con el personal escolar que necesite estar informado. ☐si ☐no

FOR INHALERS AND EPIPENS ONLY (PARA INHALADORES Y EPIPENS SOLAMENTE):

- I give my permission for the nurse to initiate an Emergency Care Plan/504 Plan. ☐yes ☐no

Yo doy mi permiso para la enfermera de iniciar un plan de cuidado de emergencia/0 plan 504. ☐si ☐no

- I give my permission for my student to carry his/her emergency medication. ☐yes ☐no
- My student is trained and may self-administer their own emergency medication: ☐yes ☐no

Doy permiso para que mi estudiante pueda traer su medicamento de emergencia. ☐si ☐no

Mi estudiante tiene conocimiento y entrenamiento de administrarse su propio medicamento de emergencia. ☐si ☐no

Parent/Guardian Signature _____ Date _____ Home Phone _____ / Emergency Phone _____

HEALTH CARE PROVIDER SECTION

Diagnosis for which medication is to be given during school hours: _____

Asthma Diagnosis: ☐ Mild Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Name of medication (1 per form): _____ Dosage: _____ Method of administration: _____ Time of day to be given: _____

If given **prn**, specify length of time between doses: _____

Other directions for use: _____

Possible side effects: _____ Emergency Action: _____ or ☐ 911

Duration of Order (must choose one)

☐ Medication is ordered for duration of current school year (which may include summer school)

☐ Medication to be given from ____/____/____ to ____/____/____.

FOR INHALERS AND EPIPENS ONLY:

May this student carry his/her emergency medication? ☐yes ☐no

Is this student trained/can self administer his/her own emergency medication? ☐yes* ☐no

**If yes, this student has received instruction in the correct and responsible way to use the medication.*

FOR STUDENTS WITH ASTHMA OR ANAPHYLAXIS: The HCP must submit

"A written treatment plan for managing asthma or anaphylaxis episodes of the student and for medication use by the student during school hours" RCW 28A.210.370.

HCP Signature _____ Date _____

HCP Printed Name _____ Phone _____