Authorization to Administer Medication at Eatonville Public Schools

Parent/Guardian complete the section below.

School: Fax # Grade

Student Last, First Name: Date of Birth

Health Care Provider: Health Care Provider Phone

Health Care Provider Fax #

Please Check One Box:

- (•) I request that authorized persons at my school assist my child in taking medicine described below. I also give my permission for the exchange of information between the school nurse and the Health Care Provider
- ( ) I request that my child be allowed to self-administer medication. I also give my permission for the exchange of information between the school nurse and Health Care Provider. I shall hold harmless and indemnify the Eatonville School District, its agents, employees, and board members against all claims, judgments, or liability arising out of self-administration and carrying of medication by my child.
- ( ) I am 18 years or older and am signing this form on my own behalf (RCW 26.28.015 or RCW 70.02.130) to request that I be allowed to self-administer medication. I also give my permission for the exchange of information between the school nurse and my Health Care Provider. I shall hold harmless and indemnify the Eatonville School District, its agents, employees, and board members against all claims, judgments, or liability arising out of self-administration and carrying of medication.

Parent/Guardian Signature: _____ Date

Primary Phone Emergency Phone

Health Care Provider complete the section below.

I have determined that the medication named below is advisable during the school day.

Diagnosis for Medication given: _____

Name of Medication Dose:

Route: _____

If medicine is to be given DAILY, what time? _____

If medicine is to be given AS NEEDED, describe indications:

How soon can it be repeated:

Is child authorize to self-administer? Circle one **YES** **NO**

If YES, student has been trained by Health Care Provider and is safe to self-administer Circle one **YES** **NO**

Length of time this treatment is recommended

Possible side effects

Emergency procedure in case of serious side effects

Health Care Provider Signature: _____ Date

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Whenever possible, we encourage medication doses to be scheduled **during non-school hours.** For students that require medication during school hours, see below for Washington State Law requirement RCW 28A.210.260.

1. **ALL** medication (including over the counter) administered at school require the authorized signature of both parent/guardian and licensed Health Care Provider.

2. Medication must be labeled properly (see below) and in its original pharmacy container.
    a. Student Name.
    b. Name and Strength of medication (including dosage to be given).
    c. Time and method of administration.
    d. Length of time/day(s) to be given.

3. Medications other than oral, eye, ear or topical may need to be administered by a licensed nurse. Epinephrine auto injectors (Epi-Pen, Auvi-Q) are an exception. Please contact your school nurse for more information.

Authorized Medication form must be completed and on file at the student's school, before medication can be given.

Thank you,

Eatonville School District
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Eatonville, WA 98328
Phone (360) 879-1000
Fax (360) 879-1086