NORTH KITSAP SCHOOL DISTRICT

Authorization for Medication Administration at School

School year _____

School _____

Health Services Phone 360-396-3580

Health Services Fax 1-888-784-3535

1. This form is required for all prescription and non-prescription medication stored at school.
2. A separate form is required for permission to self-carry epinephrine autoinjectors and/or inhalers.
3. There must be a valid health reason which requires school staff to give this medication at school.
4. **A new authorization form is required each school year and is subject to approval.**
5. The parent/guardian should deliver the authorization form with the medication to the school office.
6. The medication should be in the original container and be unexpired.
7. For split tablets, medication must be split by a pharmacist or parent/guardian before bringing it to school.

**** THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH PROFESSIONAL ****

Name of Student: _____ Date of Birth: _____

Reason for Medication: _____

Name of Medication: (one per form) _____

Dosage & Mode of Administration: _____

If given for allergic reason, describe indicators: _____

Time to be given: _____

Inclusive dates during which medication is to be given: (current school year, if left blank) _____

Possible side effects of medication: _____

Action or first aid measures required if side effects occur:

_____ _____

Printed Name of Licensed Health Professional | Phone

_____ _____

Signature of Licensed Health Professional | Date

**** THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN ****

- I request that an authorized staff member assist my student in taking this medication as ordered by the provider.
- I understand that every effort will be made by school staff to administer the medication in a timely manner, but it is possible for a dose to be delayed or missed.
- I will keep track of the expiration date and replace the medication before it expires.
- I understand that leftover medication will be discarded at the end of the school year if not picked up.
- I agree to hold North Kitsap School District harmless for any liabilities it may incur in connection with this requested medication at school when medication is administered in accord with LHP's written direction.

_____ _____

Printed Name of Parent/Guardian | Phone

_____ _____

Signature of Parent/Guardian | Date