

For _____ school year
 [Expires at the end of August]

PERMISSION TO ADMINISTER MEDICATION AT SCHOOL

KELLOGG MIDDLE SCHOOL 16045 25th Ave NE Shoreline, WA 98155 SHORELINE SCHOOL DISTRICT	ATTENTION: KELLOGG NURSE FAX: 206.393.4780 PHONE: 206.393.4790 fk.nurse@ssd412.org
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Student _____ Birth date _____ Grade _____ Age _____
 Parent _____ Address _____ Phone _____
 Licensed health professional _____ Phone _____ Fax _____

This section to be completed by PARENT or GUARDIAN:

I request that the school nurse, or designated staff member, administer the medication(s) described below as directed by the above licensed health professional. I accept responsibility for supplying the medication in the original container, and for immediately notifying the school nurse (or principal) of any change in these instructions.

I give my consent for the confidential information contained on this form to be FAXed to the above named school.

Parent/Guardian signature **Date**

This section to be completed by LICENSED HEALTH PROFESSIONAL:

MEDICATION	DOSAGE	ROUTE	TIME TO BE GIVEN

Health condition requiring administration of medication _____

Possible side effects: _____

Other instructions: _____

I request and authorize that the above-named student be administered the above-identified medication as per the instructions indicated above from [dates] _____ to _____ [not to exceed current school year] as there exists a valid health reason which makes administration of the medication advisable during school hours.

Signature of Licensed Health Professional with Prescriptive Authority **Name [PRINT OR TYPE]** **Date**