For ______________school year
[expires at the end of August]

Shoreline School District

Shoreline, WA, 98155

PERMISSION TO ADMINISTER MEDICATION AT SCHOOL

Echo Lake Elementary School
Shoreline School District
19345 Wallingford Ave. North
Shoreline, WA 98133

ATTENTION: Amy Grindle, BSN, RN
Jennie Wilkie, BSN, RN

FAX: 206.393.4335 PHONE: 206.393.4332

e-mail: EL.nurse@ssd412.org

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(s) for health reason which makes administration of the medication advisable during school hours.

As per the instructions indicated above from ______________ To ____________ (not to exceed the school year)

____ ____________________________________ _____________

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

Rev 5/2/03:kj *MD, DO, DDS, PA, ARNP