GOLDENDALE SCHOOL DISTRICT
HEALTH SERVICES DEPARTMENT

Primary School	Middle School	High School
Phone: 509-773-4665	Phone: 509-773-4323	Phone: 509-773-5846
Fax: 509-773-6602	Fax: 509-773-4579	Fax: 509-773-8019

MEDICATION AUTHORIZATION

Please **complete a separate form for each medication,** including prescription and non-prescription medication.

Student: ____ Date of birth: ______________ Grade: ______

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

I certify I am the parent or legal guardian of the above named student and request/authorize the school to administer medication to the above named student in accordance with the Licensed Health Professional's instructions for Date: ___________to _________ (not to extend past one calendar year, but to include: **the current school year, summer school, and summer sports**) *and to share information about this medication and diagnosis with school staff on a "need to know" basis.*

I give permission for my child to carry this medication/inhaler/epi-pen on person at school.• Yes • No
I give permission for my child to self-administer this medication/inhaler/epi-pen at school. • Yes • No
If student carries and self-administers medication, I understand that I, the parent/guardian, am responsible for ensuring that my student has his/her medication with himself/herself at all times.

Parent/guardian signature: _________________________________ Date: _______ Phone: ________________

♦THIS PORTION TO BE COMPLETED BY THE HEALTH CARE PROVIDER (HCP)♦

Diagnosis for which medication is given: ____

Severity of diagnosis: • Mild • Moderate • Severe

Medication: ____ Route/form of medication: _______________________

Dose: ____ Repeat Dose: ________________________________

When/Time: ____

Side effects of drug to be expected: ____

Patient: • may • may not keep aforementioned medication on person.
• may • may not self-administer aforementioned medication.

I request and authorize the above named student to be administered the aforementioned medication in accordance with the instructions noted above for the Date: _____________ to _________ (not to extend past one calendar year, but to include: **the current school year, summer school, and summer sports**) as there exists a valid health reason making administration of the medication advisable during school hours.

HCP signature: ____ Date: ________________________

HCP printed name: ____ Phone: _______________________

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 28.210.370