For _____school year
[expires at the end of August]

PERMISSION TO ADMINISTER MEDICATION AT SCHOOL

Cascade K-8 Community School
Home Education Exchange
Shoreline School District
2800 N.E. 200th St.

ATTENTION: Julie Etscheid, BSN, RN
FAX: 206-393-4183
PHONE: 206-393-4187
EMAIL: ck8.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 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* **Name [PRINT OR TYPE]** **Date**

***MD, DO, ARNP, PA, DDS**

Rev 10/24/13:sg