Medication at Lakeside School

The following is applicable to summer programs/camp hosted at Lakeside School. Whenever possible, we encourage medication doses to be scheduled **during non-school hours**. For students that require medication during summer programs/camp hours, see below for Washington State Law requirement RCW 28A.210.260.

1. ALL medication (including over the counter) administered at school require the authorized signature of a parent/guardian and licensed Health Care Provider.
2. Medication must be labeled properly (see below) and in its original pharmacy container or manufacturer's packaging.
    a. Student's Name.
    b. Name and Strength of medication (including dosage).
    c. Time and method of administration.
    d. Duration/frequency of administration
3. Medications other than oral, eye, ear or topical may need to be administered by a licensed nurse. Epinephrine auto injectors (Epi-Pen, Auvi-Q) are an exception. Please contact your school nurse for more information.

Use this form to document medications not covered by specific Action Plans (e.g., Allergy, Asthma, Diabetes, Seizure). It includes short-term and as-needed medications, prescription meds (e.g., ADHD, migraines, depression), and over-the-counter meds used during summer programs/camp hours. **If your child has an Action Plan that covers their prescribed medication, you do not also need to fill out this form for those same medications.**

All meds must be provided by the student/parent/guardian, with options for storage in the Health Room or self-carry following guidance from their prescribing healthcare provider.

An authorized medication form must be completed and on file with the Lakeside School Nurse before medication can be given.

Lakeside School 14050 1st Ave NE Seattle, WA 98125	Lakeside Middle School 13510 1st Ave NE Seattle, WA 98125

ATTENTION:	Joy Irvin, School Nurse
PHONE:	(206)440-2906
FAX:	MS: (206)368-3639 US: (206)368-2638
EMAIL:	joy.irvin@lakesideschool.org

Medication at Lakeside School

Parent/Guardian complete the section below:

Student Name _____
Date of Birth _____**Grade**_____

Valid for ☐ 2024 summer programs ☐ 2024-2025 school year ☐ 2025 summer programs

Health Care Provider: _____
Phone _____ Fax _____

Please Check One Box:

☐ I request that authorized persons at my school assist my child in taking medicine described below. I also give my permission for the exchange of information between the school nurse and the Health Care Provider. As a result of this authorization, I agree to indemnify and hold harmless Lakeside School, its agents, employees, and board members against all claims, judgments, or liability who administer and/or monitor the medication.

☐ I request that my child be allowed to self-administer medication. I also give my permission for the exchange of information between the school nurse and Health Care Provider. I shall hold harmless and indemnify Lakeside School, its agents, employees, and board members against all claims, judgments, or liability arising out of self-administration and carrying of medication by my child.

☐ I am 18 years or older and am signing this form on my own behalf (RCW 26.28.015 or RCW 70.02.130) to request that I be allowed to self-administer medication. I also give my permission for the exchange of information between the school nurse and my Health Care Provider. I shall hold harmless and Lakeside School, its agents, employees, and board members against all claims, judgments, or liability arising out of self-administration and carrying of medication.

By signing below, I confirm that I have discussed Lakeside School's medication policy with my child. For a student authorized to self-administer medication, I affirm that I have reviewed and discussed the following guidelines with my child:

- Adherence to the healthcare provider's medication order.
- Proper medication administration technique.
- Personal responsibility for medication, not to be shared with other students.
- Limiting daily carry to one day's supply, except for multi-dose devices (like inhalers).
- Notifying the school nurse if symptoms persist, recur, or side effects are suspected.

I acknowledge that my child's permission for self-administration of medication may be revoked if these guidelines are not followed.

Parent/Guardian Signature:
Date

LAKESIDE SCHOOL

Health Care Provider complete the section below:

Prescription Medications (one medication per page)

Student Name_____ **DOB** _____ **Valid for** ☐ 2024 summer programs ☐ 2024-2025 school year ☐ 2025 summer programs	
Name of medicine:	
Diagnosis for which medication is given:	
Form and dose:	
Route:	
If the medication is to be given DAILY, at what time?	
If the medication is to be given WHEN NEEDED, describe indications:	
How soon can it be repeated?	
Side effects of the drug (if any) to be expected:	
Other:	
☐ **YES – self carry & self-administer** I have instructed this student in the proper way to use his/her/their medications. It is my professional opinion that this student should be allowed to carry and use that medication by him/her/their self, unless medically unable to do so. ☐ **NO – self carry & self-administer** It is my professional opinion that this student should not carry his/her/their medication by him/her/their self. It should be stored in a safe place for quick access and not on their person.	
Signature of Licensed Health Provider with Prescriptive Authority: **Date:**	
Health Care Provider: _____ Phone _____ Fax _____	

LAKESIDE SCHOOL

Parent/Guardian & Health Care Provider complete the section below:

Over-the-Counter Medications

(Note to parents/guardians: complete with provider only if you would like this medicine available to your child for a school day, otherwise disregard.)

Student Name_____ **DOB** _____

Valid for ☐ 2023-2024 school year ☐ 2024 summer programs ☐ 2024-2025 school year

Indication	Medication	Dose & Frequency	Route	Other instructions
Pain discomfort, mild headache, menstrual cramps, fever, cold or viral conditions	Motrin/ ibuprofen	Children 12 years or older: 200mg tabs, take 2 every 6 hours as needed Children 6 to under 12 years: consult your doctor	PO/ by mouth	Do not administer for head injuries
Pain discomfort, mild headache, dysmenorrhea, fever, cold or viral conditions	Tylenol/ acetaminophen	Children 12 years or older: 325mg tabs, take 2 every 6 hours as needed Children 6 to under 12 years: consult your doctor	PO/ by mouth	Do not administer for head injuries

☐ **YES – self carry & self-administer**

I have instructed this student in the proper way to use his/her/their medications. It is my professional opinion that this student should be allowed to carry and use that medication by him/her/their self, unless medically unable to do so.

☐ **NO – self carry & self-administer**

It is my professional opinion that this student should not carry his/her/their medication by him/her/their self. It should be stored in a safe place for quick access and not on their person.

Signature of Licensed Health Provider with Prescriptive Authority:

Date:

Health Care Provider: _____

Phone _____ Fax _____