Medication Expiration Date:_____

Tumwater School District
Licensed Health Care Provider's Orders for Medication at School

School Year	School	Fax

Student Name:_____ DOB:_____

Medication is ordered to be given to a student at school only when absolutely necessary. Whenever possible, the parent and health care provider are urged to design a schedule for giving medication outside of school hours. If this is not possible, it must be understood by the parent that the medication will be dispensed by the principal or his/her designee if the school nurse is not present. The principal will designate the person responsible to dispense medication on an individual basis. The school accepts no liability for untoward reactions when the medication is administered in accordance with the health care provider's directions.

Is it necessary to dispense this medication during school hours? Yes No

Name of Medication	**Dosage**	**Methods of Administration**	**Time of Day to be Taken**
_____	_____	_____	_____

If PRN (as needed) specify minimal time interval **between doses:**_____

Reason for medication to be given during school hours:_____

_____

Permission to carry (circle) **Inhaler: YES_____ NO_____;Epi-Pen: YES_____ NO_____;**
Insulin: YES_____ NO_____ (insulin injection may not be delegated to unlicensed staff)

Possible side effects of medication:_____

Emergency procedure in case of serious side effects:_____

_____

Physician Signature:_____ Print or stamp name:_____

Date:_____Phone:_____Fax:_____

THIS AUTHORIZATION IS GOOD FOR THE CURRENT SCHOOL YEAR ONLY.

Parent's Permission

I request that the school nurse, principal or designated staff member be permitted to administer to my child, (name of child) _____, or allow my child to carry and self-administer as indicated above, the medication prescribed above for a period this school year from _____ to _____. The medication is to be furnished by me in the original container with the name of the medicine, the amount to be taken, and when it should be taken. I understand that my signature indicates my understanding that the school accepts no liability for untoward reactions when the medication is administered, or my child self administers, in accordance with the health care provider's directions. If notified by school personnel that medication remains at the end of the school year, I will collect the medication from the school or understand that it will be destroyed. I am the parent or the legal guardian of the child named.

Do you want medication to be given on half-days of school? Yes No Not Applicable

Phone Contacts

_____ Cell:_____Work:_____ _____
Parent/Guardian Signature Home:_____Other:_____ Date

Thank you for your assistance. Please return completed form to school nurse.

Student demonstrates skill level necessary to self-administer medication as ordered above. Yes No NA

School Nurse Signature: Date:

New Market Skills Center | 7299 New Market St SW | Tumwater, WA 98501
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