AUTHORIZATION FOR ADMINISTRATION OF ORAL MEDICATION AT SCHOOL
PRESCRIPTION & NON-PRESCRIPTION
Grand Coulee Dam School District
NOT to be used for inhalers or epi-pens

Student Name:___________________________________ **Birth Date:**_________________ **Grade:**_______ **School Yr:**_____________

THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH PROFESSIONAL (LHP) PRESCRIBING WITHIN THE SCOPE OF THEIR PRESCRIPTIVE AUTHORITY

Name of Medication	Dosage	Time(s) to be Taken	Time Interval if PRN

Diagnosis or reason for medication: ______________________________

Possible side effect of medication: ______________________________

Emergency procedure in case of serious side effects: ______________________________

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Diagnosis or reason for medication: ______________________________

Possible side effect of medication: ______________________________

Emergency procedure in case of serious side effects: ______________________________

Name of Medication	Dosage	Time(s) to be Taken	Time Interval if PRN

Diagnosis or reason for medication: ______________________________

Possible side effect of medication: ______________________________

Emergency procedure in case of serious side effects: ______________________________

I request and authorize that the above-named student be administered the above identified medication(s) in accordance with the instructions indicated above for the duration of the current school year, as there exists a valid health reason which may make administration of the medication advisable during school hours.

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Provider Signature **Date** **Provider Printed Name** **Phone Number**

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

- I request this medication to be given as ordered by the Licensed Health Professional
- I give Health Services Staff permission to communicate with the Nurse & Health Care Provider about this medication. I understand that oral medications may be administered by non-licensed staff members who have been trained and are supervised by a Registered Nurse.
- Medication information may be shared with school staff working with my child and 911 staff, if they are called.
- All medication supplied must come in its originally provided container with instructions as noted above by the licensed health professional.
- I request and authorize my child to carry and/or self-administer their medication ☐ Yes ☐ No

______________________________________ ______________________________________

Parent/Guardian Signature **Date** **Reviewed by School Nurse RN** **Date**