

School: \_\_\_\_\_  
Return Fax #: \_\_\_\_\_  
Attn School Nurse: \_\_\_\_\_



# School Medication Orders

For (Student Name): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**The following section is to be completed by the LICENSED HEALTH CARE PROVIDER:**

**Medication Name:** \_\_\_\_\_

**Reason for which medication prescribed:** \_\_\_\_\_

\_\_\_\_\_

**Medication Order Duration:**       Entire current school year      **OR**       Start \_\_\_\_\_ & End \_\_\_\_\_

**Medication Administration Guidelines:**

**Dosage:** \_\_\_\_\_      **Strength:** \_\_\_\_\_

**Form:**       Tablet / capsule       Liquid       Inhaled       Nebulized       Injection       Other \_\_\_\_\_

**Frequency:**

Scheduled times to be given: \_\_\_\_\_

PRN/When needed. Describe indications and frequency: \_\_\_\_\_

\_\_\_\_\_

**Restrictions and/or significant side effects?** \_\_\_\_\_

**If prescribing an asthma inhaler or epinephrine injection, may the student carry the medication?**

No or Not Applicable

Yes & I have instructed this student on purpose, appropriate method, frequency of use & student demonstrates necessary skill to use the medication including any device necessary for administration.

**Any special requirements for medication storage?** \_\_\_\_\_

**Licensed Health Care Provider Signature:** \_\_\_\_\_      **Date:** \_\_\_\_\_

**Printed HCP name:** \_\_\_\_\_      **Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_      **Fax:** \_\_\_\_\_

**The following section is to be completed by the PARENT/ GUARDIAN**

I request that the principal, or a staff member designated by her/him, be permitted to dispense the licensed health care provider authorized medication as described. I also give my permission for the exchange of information between the school district staff and the health care provider listed. I understand that the medication is to be furnished by me in its original container labeled by the pharmacy or prescriber with the name of the medication, the amount to be taken, frequency of administration, and name of health care provider. I understand that my signature below indicates my understanding that the school accepts no liability for reactions when the medication is administered in accordance with the physician's directions. This authorization is good for the current school year only. If my child's physician or authorized prescriber authorizes the student to medicate himself/herself at school, I, the parents/guardian, shall hold harmless and indemnify the school and Snoqualmie Valley School District's officers, employees and agents against all claims, judgments, or liabilities arising out of the self-administration and carrying of medication by the above named student. If necessary, the school district may discontinue administration of the medication with proper advance notice. If notified by school personnel that medication remains after the course of treatment, I will collect the medication from the school or understand that it will be destroyed by the school nurse. I am the parent or legal guardian of the child named. According to state law no distinction will be made between prescription and over the counter medication. Therefore, this form must be signed by parent/guardian AND physician for over-the-counter and prescription medicines.

**Parent/Guardian Signature:** \_\_\_\_\_      **Date:** \_\_\_\_\_      **Phone:** \_\_\_\_\_

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## Parent/Guardian Instructions for Student Medications at School

The rules of the SVSD Medication Policy are written to comply with the legal requirements of Washington State Law and dictate that for a student to be allowed medication (prescription or over-the-counter medication) at school, the student's parent/guardian needs to provide the school district the following:

- **School Medication Order**
  - Completed school medication form
  - Includes licensed healthcare provider & parent signatures
  - Current (new form completed each school year)
  
- **Medication Itself**
  - In the original container
  - Matches the order request
  - Non-expired

### **Additional Requirement Information:**

District policy dictates that the school be in possession of a current and complete written request from a licensed healthcare provider, prescribing within their scope of prescriptive authority, along with parent permission, for any medication (either prescription or over-the counter) to be at school and before it can be dispensed. Nor should students have any medication in their possession without this in place as this would violate school drug policy and potentially be subject to discipline. A **current completed School Medication Order form** fulfills the requirement.

One important requirement of state law relates to **over-the-counter (non-prescription) medication**. RCW 28A.210.260 and 270 does not make a distinction between prescription and non-prescription medication. Both require a medication order signed by a licensed healthcare provider.

Another important requirement relates to **emergency medications** at school for potentially life-threatening conditions (i.e. allergies, asthma, seizures, etc.). Students with these conditions may be required to have emergency medications and orders at school to be allowed to attend school. Students who have had emergency medication at school previously (i.e. epinephrine, rescue inhalers, Diastat, nasal midazolam, etc.) need to have these medications and the medication order, turned in prior to the first day of school. If the emergency medication is no longer medically necessary, a signed licensed health care provider letter indicating this is needed to discontinue it and have the student no longer subject to this attendance requirement.

Please feel free to reach out to me, your school nurse, if you have any questions/concerns about having medication at school for your student.

Nurse Name and Contact Info