GOLDENDALE SCHOOL DISTRICT
HEALTH SERVICES DEPARTMENT

Primary School
Phone: 509-773-4665
Fax: 509-773-6602

Middle School
Phone: 509-773-4323
Fax: 509-773-4579

High School
Phone: 509-773-5846
Fax: 509-773-3194

MEDICATION AUTHORIZATION

Please **complete a separate form for each medication,** including prescription and non-prescription medication.

Student: _____ Date of birth: _____ Grade: _____

♦THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN♦

I certify I am the parent or legal guardian of the above named student and request/authorize the school to administer medication to the above named student in accordance with the Licensed Health Professional's instructions for Date: _____to_____ (to include: **the current school year, summer school, and summer sports; reauthorization required at the start of every school year**) *and to share information about this medication and diagnosis with school staff on a "need to know" basis.*

I give permission for my child to carry this medication/inhaler/epi-pen on person at school. ☐ Yes ☐ No
I give permission for my child to self-administer this medication/inhaler/epi-pen at school. ☐ Yes ☐ No
If student carries and self-administers medication, I understand that I, the parent/guardian, am responsible for ensuring that my student has his/her medication with himself/herself at all times.

Parent/guardian signature: _____ Date: _____ Phone: _____

♦THIS PORTION TO BE COMPLETED BY THE HEALTH CARE PROVIDER (HCP)♦

Diagnosis for which medication is given: _____

Medication: _____ Route/form of medication: _____

Dose: _____ Repeat Dose: _____

When/Time: _____

Side effects of drug to be expected: _____

Patient: ☐ may ☐ may not keep aforementioned medication on person.
☐ may ☐ may not self-administer aforementioned medication.

I request and authorize the above named student to be administered the aforementioned medication in accordance with the instructions noted above for the Date: _____ to _____ (to include: **the current school year, summer school, and summer sports; reauthorized required at the start of every school year**) as there exists a valid health reason making administration of the medication advisable during school hours.

HCP signature: _____ Date: _____

HCP printed name: _____ Phone: _____

FOR STUDENTS WITH ASTHMA OR ANAPHYLAXIS: The HCP must submit "A written treatment plan for managing asthma or anaphylaxis episodes of the student and for medication use by the student during school hours." RCW 28.210.370