AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Medication is ordered to be given to a student at school only when absolutely necessary. Only trained staff members will dispense this medication. When both physician and parent indicate permission, student may carry and self-administer inhaler for asthma, Epi-Pen for allergy, and/or insulin for diabetes. Trained staff members at Orting School District will administer only oral medication. This district accepts no responsibility for untoward reactions when medication is dispensed in accordance with the physician/dentist's directions.

PHYSICIAN/DENTIST PERMISSION AND DIRECTIONS

It is necessary to dispense this medication during school hours. Yes ____ No ____

Name of Patient: _____

Diagnosis or Reason: _____

Oral Medication and dosage form: _____

Dose of medication: _____

Hour(s) to be given: _____

Duration without subsequent order: _____

(Within dates of current school year only)

Adverse effects of medication (if any) to be expected: _____

Diabetes supplies to be carried by student **YES ( ) NO ( )**

Inhaler to be carried by student **YES ( ) NO ( )**

Severe allergy medication to be carried by student **YES ( ) NO ( )**

_____ _____ _____ _____

(Physician signature) **(Printed Name)** **(Physician phone #)** **(Date)**

PARENT/GUARDIAN PERMISSION INFORMATION

I request that trained school personal dispense to my child, (name) _____the medication prescribed above by (physician/dentist name) _____ during the dates from _____ to _____.

I will furnish the medication **in the original container** labeled by the pharmacy or physician (for prescription meds) with the name of the medicine, the dose to be taken, and the time of day to be taken. Medication will only be **dispensed within the time designated by physician/dentist**. I understand I will not contact the school asking that they dispense extra doses at off times, or to change the dose amount to be taken. My child's name and physician/dentist name is on the label with directions, time, and dose. I understand that my signature indicates my understanding that the school accepts no liability for untoward reactions when the medication is administered in accordance with the physician/dentist directions.

This authorization is for the current school year only. In case of necessity, the school district may discontinue administration of medication with proper advance notice to me. I understand that remaining medication after the course of treatment will be picked up by an adult, or will be disposed of by school staff. I am the parent or legal guardian of the child named on this form.

I give permission for my child to carry and self-administer his/her supplies for diabetes care. YES ( ) NO ( )
I give permission for my child to carry and self-administer his/her inhaler for asthma. YES ( ) NO ( )
I give permission for my child to carry and self-administer his/her Epi-Pen for allergy. YES ( ) NO ( )

For safety reasons, I understand all other medications will be kept in the school Health Room.
I understand that my signature below is an informed consent for the school R.N. or Health Tech. to share the health information on this form with school staff/911 on a need-to-know basis for academic success and emergency plans as determined by the school nurse.

Date: _____ Parent/Guardian Signature: _____

Home phone # _____ Work phone # _____ Cell/Pager# _____

Deanna Wulff BSN, RN
District Nurse
Sandra Chamberlin, RN
District Nurse
360-893-6500

Dear parent/Guardian:

Washington State Law demands strict control over the **administration** of ***over-the-counter*** or ***prescription*** medication taken during school hours. This includes **cough drops**.

Washington State Regulations **REQUIRE** written permission and directions from the **physician/dentist AND parent/guardian** for **ALL** medications given during school hours. **No exceptions.**

We are not allowed to legally dispense medication and students are not allowed to have medication at school without the completed attached form.

Medications are generally kept in the health room, however, students carry some medications with health provider, parent, and district nurse approval. Examples of such medication are: Epi-Pen, inhalers, or insulin and supplies for diabetes.

We are **legally NOT** allowed to dispense medication of any kind from plastic sandwich bags, envelopes, or other containers.

All medication and doses must match the directions of the attached medication form.
____ Have your physician/dentist complete, sign and date the top portion of the attached form.
____ Complete, sign and date the lower section of the attached form, and return it to our school.

The form A**UTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL** may also be faxed to your student's school.

FAX NUMBERS FOR ORTING SCHOOL DISTRICT

Orting Elementary School (360) 893-4489
Ptarmigan Ridge Elementary (360) 893-0603
Orting Middle School (360) 893-2919
Orting High School (360) 893-5701

Thank you for your cooperation in this matter. If you have any questions, please call us at:

Orting Elementary School (360) 893-2248
Ptarmigan Ridge Elementary (360) 893-0595
Orting Middle School (360) 893-3565
Orting High School (360) 893-2246

Medication Receipt							
Date	Medication	Strength	Count	Parent Signature	Staff Signature	Rec'd	Return