STEILACOOM
Historical School District No. 1

**FOR HIGH SCHOOL OVERNIGHT / EXTENDED HOURS FIELD TRIPS**

Health Services
511 Chambers Street,Steilacoom, WA 98388
Phone: (253) 983-2223 Fax: (253) 582-9274
Email: healthservices@steilacoom.k12.wa.us

# Physician's Orders for Medication at School

| Student Name | DOB | School | FAX | School Year |
|---|---|---|---|---|
| | | | | |

**Medication is ordered to be given to a student at school only when absolutely necessary**. Whenever possible, the parent and physician 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 responsibility for untoward reactions when the medication is dispensed in accordance with the physician's directions.

Is it necessary to dispense this medication during the field trip? ❑ Yes ❑ No

If yes, please give diagnosis or reason: _____

Drugs and dosage form: _____

Dose and mode of administration: _____

Time(s) to be given: ❑ Lunch ❑ Hour _____ ❑ As Needed: _____

Duration without subsequent order: Weeks _____ Months _____ School Year _____ Other: _____

Student is allowed to self-carry: ❑ Yes ❑ No Student is allowed to self-administer: ❑ Yes ❑ No

Side effects of drug *(if any)* to be expected: _____

_____

Health Care Provider's Signature | Phone | Fax

Health Care Provider's Printed Name or Stamp | Date

THIS AUTHORIZATION IS GOOD FOR THE CURRENT SCHOOL YEAR ONLY, INCLUDING SUMMER PROGRAMS.

## Parent/Guardian's Permission

I request that the school nurse, principal or a staff member designated by him/her be permitted to dispense to my child, *(Name of Child)* _____ the medication prescribed by *(Name of Physician)* _____ for a period from _____ to _____.

The medication is to be furnished by me in the original container labeled by the pharmacy or physician with the name of the medicine, the amount to be taken, and the time of day to be taken. The physician's name is on the label.

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's directions. I request that the school nurse or designated staff be permitted to discuss my child's medical issues with health care providers and administer to my child.

**This authorization is good for the _____ school year only.**

In case of necessity 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**. I am the parent or the legal guardian of the child named.

Parent/Guardian Signature: _____ Date: _____

Phone Contacts: *Home* _____ *Cell* _____ *Work* _____ *Other* _____