AUTHORIZATION FOR MEDICATIONS AT SCHOOL Whatcom County Schools

Student_____ Birthdate_____ School_____ year_____

Medication will be administered by trained designated school personnel to a student at school only when absolutely necessary per RCW 28A.210.260-270 and RCW 18.71.030 (3). The District accepts no responsibility for unanticipated reactions when the medication is administered in accordance with the directions of the student's Health Care Provider. Orders must be nondiscretionary and legible.

This form should not be used to prescribe emergency medications or injections. **ONLY ONE MEDICATION PER FORM**

Section #1: To be completed by the PARENT/GUARDIAN

Please check only one box:

☐ I request that authorized staff administer the medication indicated in section #2. Health Care Provider's signature needed.

☐ I request that my child be allowed to **self-administer prescription** medication indicated in section #2. Health Care Provider's signature needed.

☐ I request that my child be allowed to **self-administer over-the-counter medication** (RCW 26.28.015 or RCW 70.02.130). Parent must sign below and complete medication information in section #2. No Health Care Provider signature is needed.

- **By signing this, I consent to exchange of information regarding this medication authorization between the school and the Health Care Provider. I have read and understand the information on page 2 of this form**

_____ _____ _____

Date Parent/Guardian signature Phone

Section #2: To be completed by the HEALTH CARE PROVIDER (or parent, if over-the-counter self-administered)

This medication will be: ☐ staff administered ☐ self-administered (student has demonstrated the skill level necessary)

Diagnosis/reason for medication_____

Name of medication _____ Dose to be given: _____

☐oral (MDI, Nebulizer inclusive) ☐topical ☐eye drops ☐ear drops ☐nasal ☐rectal ☐other: _____

Specific Time(s) : AM : PM and frequency of administration _____

_____

Possible side effects _____

Length of prescription ☐ current school year (including summer school) ☐ other:_____

I request and authorize that the above-named student be administered or be allowed to self-administer the above-identified medication in accordance with the instructions indicated.

_____ _____

Licensed Health Care Provider signature Date

_____ _____

LHCP printed name Telephone number

Parent/Guardian Information and Asthma Action Plan located on back of form. **OVER ⇒**

5/13/2016

PARENT/GUARDIAN INFORMATION REGARDING MEDICATIONS IN SCHOOL

I certify that I am the parent, legal guardian, or other person in legal control of this student. I request and authorize the school to administer the medication prescribed, as authorized by RCW 28.A210.260-270 and RCW 18.71.030 (3). This includes oral, inhaled, topical, nasal, rectal, eye and ear drops that shall be given at school **only when absolutely necessary**. Designated/trained employees shall administer this medication in compliance with Licensed Health Care Provider (LHCP) orders.

I understand the medication must be furnished in the **current, original container** from the pharmacy with the student's name, the name of the medication and the amount to be given. Non-prescription medication must be furnished in the original container from the manufacturer. All medication must be in a form ready to be administered and **must not** require any preparation by building staff. If the dosage or time should change, new orders and container will be provided.

I understand it is **my** responsibility to deliver and maintain an adequate supply of the medication at school.

I understand medication orders are only valid for the current school year (including summer school). Any medication remaining at the end of the school year, not picked up immediately after the last day of school, will be disposed, with the exception of Extended School Year students.

If self-administration is requested (and approved by principal/nurse), I certify that my child has the skill level necessary to do so, and that the school will assume no responsibility/liability for the administration of the medication or its use. Student may only carry a one day supply of oral medication.

ASTHMA ACTION PLAN

☐ **Intermittent** has symptoms of wheezing and coughing no more than 2 days a week, with nighttime flare-ups twice a month or less. Outside to these few episodes, a student is free of symptoms.

☐ **Mild** Symptoms occur more than twice a week but less than once a day, flare-ups may affect activity.

☐ **Moderate** Symptoms occur daily, flare-ups usually last several days. Symptoms disrupt normal activities and make it difficult to sleep.

☐ **Severe** Symptoms occur daily and often, also curtail the student's activities and disrupt sleep.

WARNING SIGNS OF AN ASTHMA ATTACK:	EMERGENCY RESCUE PLAN:
• Constant cough • Difficulty breathing with struggling or gasping for breath, or an audible wheeze with breathing • Stooped body posture • Trouble walking or talking, or stops playing and can't start activity again • Lips or fingernails are grey or blue (light complexion only) • _____	• Remove student from known triggers, if possible. • Accompany student to health room • Give medication as prescribed: • Keep student sitting up and reassure student • Encourage student to drink warm fluids
• No improvement 15-20 minutes after initial treatment with medication.	• Notify parent. • Call school nurse • If parents are unable to come within 10 min call 911
If student is in severe distress	**Call 911.** Notify parent, principal and school nurse.