

For _____ school year
(expires at the end of August)

PERMISSION TO ADMINISTER MEDICATION AT SCHOOL

**Briarcrest Elementary School
2715 NE 158th St.
Shoreline, Washington 98155**

**ATTENTION: Susan Vieira, RN
PHONE 206.393.4176
FAX 206.393.4174
EMAIL: susan.vieira@ssd.412.org**

Student _____ Birth date _____ Grade _____ Age _____
Parent _____ Address _____ Phone _____
Licensed health professional _____ Phone _____ Fax _____

This section to be completed by PARENT or GUARDIAN:

I request that the school nurse, or designated staff member, administer the medication(s) described below as directed by the above licensed health professional. I accept responsibility for supplying the medication in the original container, and for immediately notifying the school nurse (or principal) of any change in these instructions. I give my consent for the confidential information contained on this form to be FAXed to the above named school.

Parent/Guardian Signature _____

Date _____

This section to be completed by LICENSED HEALTH PROFESSIONAL:

MEDICATION	DOSAGE	ROUTE	TIME TO BE GIVEN

Health condition requiring administration of medication _____

Possible side effects: _____

Other instructions: _____

I request and authorize that the above-named student be administered the above-identified medication as per the instructions indicated above from [dates] 09/01/ to 08/31/ [Not to exceed current school year] as there exists a valid health reason which makes administration of the medication advisable during school hours.

**Signature of Licensed Health Professional
with Prescriptive Authority *** _____

Name [PRINT OR TYPE] _____

Date _____