

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Dear Parent/Guardian:

We understand that for a variety of reasons, students must take medication at school. Because of our constant concern for child safety, the Tahoma School District is regulated by the state laws listed below and School Board Policy 3416 which states, in part:

Medication at School: Under normal circumstances, all student medications, both prescription and over-the-counter (OTC) medications should be administered before and/or after school hours under supervision of the parent/guardian. When it is necessary for a student to receive prescription OTC oral medication, topical medication, eye drops or ear drops or nasal spray at school or at school-sponsored events, the parent/guardian must submit a written parental request and a written authorization form from a licensed healthcare practitioner (LHP) prescribing within the scope of his or her prescriptive authority. If the medication will be administered for more than fifteen consecutive days, the LHP must also provide written, current and unexpired instructions for the administration of the medication.

RCW 28A.210.260 Public and private schools -- Administration of oral medication by -- Conditions.

RCW 28A.210.270 Public and private schools -- Administration of oral medication by -- Immunity from liability -- Discontinuance, procedure.

Please contact your school nurse if you would like a copy of these state regulations or a full copy of our Board Policy and Procedure.

It is important to remember:

- If possible, it is best to administer medications at home.
- If this is a new medication for the student, the first dose must be given at home prior to bringing the medication to school.
- If it is necessary for medication to be administered during the school day, this form must be on file. Please take this form with you so you can have it filled out and signed by a licensed health care provider.
- This form and the prescribed medication (in the original prescribed bottle) must be delivered to the school and no more than one month of medication is to be kept on hand. (On request, a pharmacist can provide an extra container with the required information at the time the prescription is filled.)
- Under no circumstances should medication be sent to school with a child.
- Medication must be inventoried by school staff and guardian at the time of drop off.
- No school district employee can give medication, either prescription or non-prescription, without written directions from a licensed health care provider.

Additional forms are available on request. If you have any questions, please call your school's health room professional.

Cedar River Elementary School
(425) 413-5410

Tahoma Elementary School
(425) 413-3607

Glacier Park Elementary School
(425) 413-3707

Lake Wilderness Elementary
(425) 413-3543

Maple View Middle School
(425) 413-5552

Rock Creek Elementary
(425) 413-3312

Shadow Lake Elementary
(425) 413-6110

Summit Trail Middle School
(425) 413-5620

Tahoma Senior High School
(425) 413-6234

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student's Name _____ Birth Date _____
 School _____ Grade _____

THIS SECTION TO BE COMPLETED BY THE LICENSED HEALTH CARE PROVIDER

Name of Medication	Medical Condition	Dosage	Methods of Administration	Time of Day to be Taken

Please note: If samples of medication are to be given, they must be labeled with the name of the student, dosage, and time to be given.

Specify the length of time between doses: _____

Inhaler(s): _____ *Student must carry on his/her person: **YES** _____ **NO** _____

*Student is capable to self-administer medication: **YES** _____ **NO** _____

Possible side effects of medication: _____

Emergency procedure in case of serious side effects: _____

Epinephrine auto-injector/nasal spray: _____ *Student must carry on his/her person: **YES** _____ **NO** _____

*Student is capable to self-administer medication: **YES** _____ **NO** _____

Possible side effects of medication: _____

Emergency procedure in case of serious side effects: _____

I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated above from _____ through _____ (not to exceed the current school year) as there exists a valid health reason which makes administration of the medication advisable during school hours.

Date of Signature	Licensed Health Care Provider's Signature
Telephone Number	Print Name of Licensed Health Care Provider

THIS SECTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I request/authorize the school to administer medication to the above identified student in accordance with the doctor's instructions for the period _____ to _____ (not to exceed the current school year). I understand that every effort will be made by school staff to administer the medication in a timely manner.

I agree that my child has permission to carry an inhaler/epinephrine: **YES** _____ **NO** _____

I agree that my child has permission to self-administer medication: **YES** _____ **NO** _____

Parent/Guardian Signature	Date
Phone Numbers: _____	_____
Home	Work
	Cell Phone