For ___________ school year

PERMISSION TO ADMINISTER MEDICATION AT SCHOOL

Meridian Park Elementary School 17077 Meridian Ave N Shoreline WA 98133 Phone: 206-393-4151	ATT'N: Meridian Park Nurse Rodevina Lucero, RN email: rodevina.lucero.guevara@412ssd.org FAX: 206-393-4259 Phone: 206-393-4124

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] __________ to __________ [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**

Rev 5/7/03:kj;