Lake Washington School District #414 Health Services

MEDICATION ADMINISTRATION AUTHORIZATION

Student's Name:_____ Date of Birth:_____ School:_____

This section to be completed by HEALTH CARE PROVIDER

Diagnosis:	
Medication:	
Dose:	
Route:	
Frequency	**If daily, time medication should be given:**
	If PRN, indications for administration:
	Length of time between doses:
Possible side effects:	
Self-carry/Self-administration Authorization Do you authorize this student to self-carry this medication ☐ Yes ☐ No This student is trained and capable of self-administering this medication ☐ Yes ☐ No	
Duration of Order: ☐ _____ school year, including summer school ☐ Other Dates: _____	

I request and authorize that the above-named student be administered the above-named medication in accordance with the instructions indicated. There exists a valid health reason which makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials. Medication may be administered by non-licensed school personnel.

_____	_____	_____	_____	_____
Health Care Provider Signature	Printed Name	Date	Phone Number	Fax Number

This section is to be completed by PARENT/GUARDIAN

- I authorize the school to administer the above-named medication to my student as prescribed.
- I understand that over-the-counter medication must be in its original container with a valid expiration date, and prescription medication must have a pharmacy label matching the written order above. It is my responsibility to replace medication when it is used or expired.
- If my student has permission to self-carry and/or self-administer this medication, my student and I understand the responsibilities, and recognize the school will not track compliance, expiration dates, or remaining amounts.
- I agree to hold harmless and indemnify the Lake Washington School District and its officers, employees, and agents against all claims, demands, damages, costs, judgments, or liabilities arising out of the self-administration and/or carrying of medication by my student.

_____	_____	_____
Signature of Parent/Guardian	Printed Name	Date