PERMISSION TO ADMINISTER MEDICATION AT SCHOOL

District	School	School Nurse Phone	Fax
Reardan-Edwall		509-381-1340	509-267-0511

Student Name _____ **Birthday** _____ **Grade** _____

PARENT/GUARDIAN SECTION

I request that the school nurse, or designated staff member, administer the medication prescribed below, in accordance with the healthcare provider instructions and give permission for the medication and care plan information to be shared with school staff on a "need to know" basis. ☐ **Yes** ☐ **No**

_____

Parent/Guardian Signature Date Home Phone / Emergency Phone

Other directions for use _____

HEALTHCARE PROVIDER SECTION

Diagnosis for which medication is to be given during school hours _____

Signs/symptoms for which medication should be administered _____

_____

_____ _____ _____ _____

Name of medication (1 per form) **Dosage** **Method of administration** **Time of day to be given**

*If given **prn**, specify length of time between doses* _____

_____

Possible side effects _____ Emergency action _____ ☐ 911

Duration of Order (must choose one)

☐ Medication is ordered for duration of current school year (which may include summer school)

☐ Medication to be given from _____/_____/_____ to _____/_____/_____

_____

_____ _____

HCP Signature Date

_____ _____

HCP Printed Name Phone