

Authorization to Administer Medication at School

Please note: This form must be completed and signed by the parent/guardian **as well as** the student's Licensed Healthcare Provider, with prescriptive authority. This form is for both **prescription** and **non-prescription** medication, or substances used as medicine. Complete a separate form for **each** medication. All medication must be transported to and from the school by the parent or guardian. These medications are to be administered during school hours only.

PARENT/GUARDIAN REQUEST

Student Name: _____ DOB: _____ School: _____

I certify that I am the parent, legal guardian, or other person in legal control of the above-identified student. I request and authorize the school to dispense medication to the above-identified student in accordance with the prescription or LHP's instructions for the period commencing:

START DATE: _____ TERMINATION DATE: _____ in the _____ SCHOOL YEAR or END of

_____ SCHOOL YEAR-including summer school activities: YES ___ NO ___

Date	Parent/guardian Signature	Home Phone	Work Phone
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Please note

1. Prescribed medication must be provided in the original and current pharmacy labeled container with the student's name, the name of the medication, the dosage, and the time/frequency of medication administration.
2. Over-the-counter medications must be in the original container.

LICENSED HEALTHCARE PROVIDER REQUEST

Medical Diagnosis or Condition: _____

Medication: Name _____ Dose _____ Time given/Frequency: _____

☐ Tablet/Capsule ☐ Liquid ☐ Inhaler ☐ Epi-Pen ☐ Other: _____

For PRN Medication indicate frequency: _____ Symptoms: _____

☐ Medication may be repeated when and if: _____

FURTHER INSTRUCTIONS (possible reactions, etc.): This section must be completed if a medication is to be dispensed for more than 15 days _____

THIS IS A POSSIBLE EMERGENCY MEDICATION. STUDENT MAY HAVE PERMISSION TO SELF-CARRY. YES NO

I request and authorize that the above-named student be administered the above-identified medication in accordance with the instructions indicated above for the period commencing:

START DATE: _____ TERMINATION DATE: _____ in the _____ SCHOOL YEAR.

or END of _____ SCHOOL YEAR-including summer school activities: YES ___ NO ___.

There *does* exist a valid health reason which makes administration of the medication advisable during school hours or during such a time that the student is under the supervision of school officials.

Date	Licensed Healthcare Provider Signature	Name (please print)	Office Phone
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Please bring the completed form to your school or have your physician's office fax it to 360-575-7224.

LONGVIEW SCHOOL DISTRICT #122

Administration of Medications at School

Pursuant to Chapter 63, Laws of 2000, the Longview School District is authorized to administer medication to students during school hours. It is our policy that such medication will only be administered when the failure to receive the medicine may result in the student being unable to attend school and/or to be well enough to participate in learning activities. We define medication to mean all drugs, whether prescription or over-the-counter.

- The request from a parent or guardian for administration of medication at school is valid only for the medication listed and dates indicated in writing on the request form and in no case will such request be valid beyond the school year in which it was filed. Any request for administration during a subsequent school year shall require the request to be re-executed. The school district, through its Superintendent or his/her designee, may discontinue the administration of the medication. Such notice must be provided orally or in writing in advance of the date of discontinuance.
- Parents or guardians must supply the medication in the original container. Prescription labels must include the student's name, prescribing health care provider's name, the drug name and the dosage. Over the counter medications must be in the original container, preferred sealed.
- The district must also be in receipt of a request and instructions from a licensed health professional prescribing within the scope of his/her prescriptive authority.
- In addition to the above, a parent, guardian, other person in legal control of the student must complete and sign this form.
- Regarding self-carry medications: WAC 110-301-0215 3vA School-age children with a valid prescription from a health care provider may be allowed to carry and self-administer asthma medication (inhaler), anaphylaxis medication (epinephrine auto-injector), insulin (insulin pump), or glucagon (kit, nasal, or auto-injector) with signed authorization from the child's parent or guardian **and** health care provider. The authorization form must attest that the child has the skill level and knowledge necessary to use the medication and device as prescribed.