HEALTH SERVICES

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student's Name _____ Date of Birth _____

School _____ Grade _____

THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH PROFESSIONAL (LHP)
PRESCRIBING WITHIN THE SCOPE OF THEIR PRESCRIPTIVE AUTHORITY

Name of Medication	**Dosage**	**Method of Administration**	**Time of Day to Be Taken**

Diagnosis or reason for medication: _____

Possible side effects of medication: _____

Emergency procedure in case of serious side effects: _____

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

Student has been trained and is capable of self-administration of asthma and/or anaphylaxis medication:
☐ Yes ☐ No

Licensed Health Professional (LHP) Signature:_____ **Date:**_____

Name: _____ **Telephone**:_____

Address: _____

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I request / authorize the school to administer medication to the above-identified student in accordance with the Licensed Health Professional's (LHP's) instructions for the period from _____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.
If Physician & School Nurse gives permission to self carry inhaler or self-administer medication: Do you give authorization for your child to: Carry and administer inhaler and/or anaphylaxis medication _____Yes _____No

I understand that the district and its employees shall incur no liability as a result of any injury arising from the self-administration of medication by the student.

Signature _____/ _____ **Telephone:**_____/_____
(Date) (Home) (Work)

For District Nurse Use Only:

Student has demonstrated the skill necessary to administer asthma and/or anaphylaxis medication to school nurse:
☐ **Yes** ☐ **No** ☐ **N/A**

Revised 5/29/09;

HEALTH SERVICES

ADMINISTRATION OF MEDICATION AT SCHOOL

TO: Parent or Guardian

RE: Administration of Medication at School

Pursuant to Chapter 195, Laws of 1982, the Eastmont School District is authorized to administer medication to students during school hours. It is our policy that such medication will only be administered when 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 of a parent or guardian for administration of medication is valid only for the medication listed, if it is in the original container and dates indicated in writing on the request form. In no case will such request exceed one (1) school year. Any requests for administration during subsequent school year shall require the Authorization Form to be re-executed. The school district, through its chief administrator or designee, may discontinue the administration of the medication. Such notice must be provided orally or in writing in advance of the date of discontinuance.

Students are **not** to transport medication to and from school. This is an unsupervised time and the possibility of inappropriate handling of the medication and/or potential for misuse with resultant harm to a student is great. Parents or guardians need to deliver the medication to the head secretary of the building where the student attends.

The physician or dentist must complete and sign this form and is required to supply written and current instructions for administration.

Please be sure that this form, **Authorization for Administration of Medication at School**, is completed and returned to the school to be included in your child's present record.

Thank You,

Eastmont School District Health Services