



# Seattle Public Schools AUTHORIZATION FOR MEDICATIONS TO BE TAKEN AT SCHOOL

The following section is to be completed by the PARENT/GUARDIAN:

(please print)

School _____	Fax# _____	Grade _____
Student's Name _____	_____	Initial _____
Birth Date _____	ID# _____	Gender _____
_____	_____	_____
(Health Care Provider's Name)	(Address)	(Phone & Fax)
<b>Please check only one box:</b>		
<input type="checkbox"/> I request that authorized persons at school assist my child in taking the medicine described below. I also give my permission for exchange of information between the nurse and the health care provider.		
<input type="checkbox"/> I request that my child be allowed to self-administer medication. I also give my permission for exchange of information between the nurse and the health care provider. I shall hold harmless and indemnify the school and Seattle Public School District's officer, employees and agenda against all claims, judgments, or liability arising out of the self-administration and carrying of medication by my child.		
<input type="checkbox"/> I am 18yo or older & am signing this form on my own behalf (RCW 26.28.015 or RCW 70.02.130). I also give my permission for the exchange of information between the nurse and the health care provider.		
_____	_____	_____
(Date)	(Parent/Guardian/Student Signature)	(Home Phone) (Emergency Phone)

The following section is to be completed by the HEALTH CARE PROVIDER:

(please print)

I have determined that the medication named below is advisable during the school day.	
Diagnosis for which medication is given: _____	
Name of medicine: _____	Dose: _____
Route: _____	
If medicine is to be given DAILY, at what time: _____	
If medicine is to be given AS NEEDED, describe indications: _____	
_____	
How soon can it be repeated: _____	
Is child authorized to medicate herself/himself? (circle) YES NO	
If "Yes", student has been trained by health care provider and is safe to self-administer? (circle) YES NO	
Length of time this treatment is recommended: _____	
Possible side effects: _____	
Emergency procedure in case of serious side effects: _____	
Date: _____	Health Care Provider's Signature: _____

## **AUTHORIZATION FOR MEDICATIONS TO BE TAKEN AT SCHOOL cont.**

Whenever possible, we encourage medication doses to be scheduled **during non-school hours**. For those students who require medication during school hours, the following is required by Washington State Law and **must be completed and on file before any medication can be given at school**:

- 1. ALL MEDICATIONS (INCLUDING OVER THE COUNTER) ADMINISTERED AT SCHOOL REQUIRE THE AUTHORIZED SIGNATURE OF BOTH THE PARENT/GUARDIAN AND A LICENSED HEALTH PROFESSIONAL**
  
- 2. MEDICATION MUST BE IN A PROPERLY LABELED (see list) ORIGINAL PHARMACY CONTAINER**
  - Student's Name**
  - Name and Strength of Medication/Including Dosage to be Given**
  - Time and Method of Administration**
  - Length of Time/Days to be Given**
  
- 3. MEDICATIONS OTHER THAN ORAL, EYE, EAR, OR TOPICAL MAY NEED TO BE ADMINISTERED BY A LICENSED NURSE: EPINEPHRINE AUTO INJECTORS (Epi-Pen, Auvi-Q) ARE AN EXCEPTION. PLEASE CONTACT YOUR SCHOOL NURSE FOR MORE INFORMATION.**

Thank you for your cooperation.

Student Health Services  
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