

# Authorization for Medication to be taken at School Form



**Parent/Guardian complete the section below.**

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School: \_\_\_\_\_ Fax # \_\_\_\_\_ Grade \_\_\_\_\_

Student Last, First Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Health Care Provider: \_\_\_\_\_ Health Care Provider Phone \_\_\_\_\_

Health Care Provider Fax # \_\_\_\_\_

Please Check One Box:

- I request that authorized persons at my school assist my child in taking medicine described below. I also give my permission for the exchange of information between the school nurse and the Health Care Provider
  
- I request that my child be allowed to self-administer medication. I also give my permission for the exchange of information between the school nurse and Health Care Provider. I shall hold harmless and indemnify the Seattle School District No. 1, its agents, employees, and board members against all claims, judgments, or liability arising out of self-administration and carrying of medication by my child.
  
- I am 18 years or older and am signing this form on my own behalf (RCW 26.28.015 or RCW 70.02.130) to request that I be allowed to self-administer medication. I also give my permission for the exchange of information between the school nurse and my Health Care Provider. I shall hold harmless and indemnify the Seattle School District No. 1, its agents, employees, and board members against all claims, judgments, or liability arising out of self-administration and carrying of medication.

Parent/Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_

Primary Phone \_\_\_\_\_ Emergency Phone \_\_\_\_\_

**Health Care Provider complete the section below.**

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I have determined that the medication named below is advisable during the school day.

Diagnosis for Medication given: \_\_\_\_\_

Name of Medication \_\_\_\_\_ Dose: \_\_\_\_\_

Route: \_\_\_\_\_

If medicine is to be given DAILY, what time? \_\_\_\_\_

If medicine is to be given AS NEEDED, describe indications: \_\_\_\_\_

How soon can it be repeated: \_\_\_\_\_

Is child authorize to self-administer? Circle one **YES** **NO**

If YES, student has been trained by Health Care Provider and is safe to self-administer Circle one **YES** **NO**

Length of time this treatment is recommended \_\_\_\_\_

Possible side effects \_\_\_\_\_

Emergency procedure in case of serious side effects \_\_\_\_\_

Health Care Provider Signature: \_\_\_\_\_ Date \_\_\_\_\_

# Authorization for Medications to be taken at Seattle Public Schools Health Services

Whenever possible, we encourage medication doses to be scheduled **during non-school hours**. For students that require medication during school hours, see below for Washington State Law requirement RCW 28A.210.260.

1. **ALL** medication (including over the counter) administered at school require the authorized signature of both parent/guardian and licensed Health Care Provider.
2. Medication must be labeled properly (see below) and in its original pharmacy container.
  - a. Student Name.
  - b. Name and Strength of medication (including dosage to be given).
  - c. Time and method of administration.
  - d. Length of time/day(s) 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.

**Authorized Medication form must be completed and on file at the student's school, before medication can be given.**

Thank you,

Seattle Public School Health Services

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