

IMPORTANT INFORMATION

MEDICATION ADMINISTRATION AT SCHOOL

In accordance with Washington State law, oral medication (any medication taken by mouth) is defined as **EITHER** prescription medication **OR** over-the-counter medication (such as Tylenol, Advil, Benadryl, Motrin, cough syrup, etc.).

ALL oral medication **MUST BE ACCOMPANIED** by a signed *Authorization for Administration of Medication at School Form* by **BOTH** the parent and the physician/dentist. Forms are available at your student's school. We will fax the form to your health care provider upon your request and signature.

ALL medication must be in the **ORIGINAL CONTAINER**. Do not send in plastic baggies or envelopes!

ASTHMA INHALERS must also be accompanied by an *Authorization for Administration of Medication at School Form* signed by **BOTH** the parent and the physician. If the child carries the inhaler on him/her, the form must still be signed and this option marked on the form.

**CLARKSTON SCHOOL DISTRICT
AUTHORIZATION FOR ADMINISTRATION OF ORAL MEDICATION**

STUDENT NAME: _____ BIRTH DATE: _____

SCHOOL: _____ DATE: _____

THIS PORTION TO BE COMPLETED BY THE PHYSICIAN/DENTIST

<u>Name of Medication</u>	<u>Dosage</u>	<u>Methods of Administration</u>	<u>Time of Day To Be Taken</u>
_____	_____	_____	_____
_____	_____	_____	_____

<u>RN Medication</u>	<u>Dosage</u>	<u>Method of Administration</u>	<u>Time of Day To Be Taken</u>
_____	_____	_____	_____
_____	_____	_____	_____

Inhalers: _____
(Indicate if student must carry on his/her person)

Student is capable of self-administering medication: Yes No

Possible side effects of medication _____

Emergency procedure in case of serious side effects _____

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

Date of Signature

Physician/Dentist Signature

Telephone Number: _____

Name: _____

Print/or type

Please note: *If samples of medication are to be given, they must be labeled with the name of the student, dosage, and time to be given.*

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

Request the school to administer medication to the above identified student in accordance with the doctor'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.

Permission to carry inhaler Yes No Permission to self-administer medication Yes No

Date of Signature: _____ Parent/Guardian Signature: _____

Telephone: _____(home) _____(work) _____(cell)