



# 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 _____ (Last)	_____ (First)	Initial _____
Birth Date _____	ID # _____	Gender _____
_____ (Health Care Provider's Name)	_____ (Address)	_____ (Phone & Fax)

**Please check only one box:**

I request that authorized persons at school assist my child in taking the medicine(s) described below. I also give my permission for exchange of information between the school district staff and the health care provider.

I request that my child be allowed to self-administer medication. I also give my permission for exchange of information between the school district staff and the health care provider. I shall hold harmless and indemnify the school and Seattle Public School District's officers, employees, and agents against all claims, judgments, or liabilities arising out of the self-administration and carrying of medication by my child.

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 exchange of information between the school district staff 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 WHEN NEEDED, describe indications: \_\_\_\_\_

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

Is child authorized to medicate himself/herself?      yes      no

If "yes", student has been trained by health care provider and is safe to self-administer.      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: \_\_\_\_\_

Adapted from the American Academy of Pediatrics, HEO150

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

**ALL MEDICATIONS TO BE ADMINSTRATED AT SCHOOL  
REQUIRE A REQUEST FROM A LICENSED HEALTH PROFESSIONAL.**

OVER-THE-COUNTER MEDICATION/PRODUCTS

- ~ Authorization for Medications to be Taken at School Form completed by both parent AND a licensed health professional with prescriptive authority. Must be in its original container.

SHORT-TERM PRESCRIBED MEDICATION - 15 school days or less

- ~ Authorization for Medications to be Taken at School Form completed by both parent AND licensed health professional with prescriptive authority.
- ~ Medication must be in a properly labeled container (see list) from the dispensing pharmacy.
  - ~ Student's Name
  - ~ Name and Strength of Medication
  - ~ Time and Method of Administration
  - ~ Length of Time/Days to be Given

LONG-TERM PRESCRIBED MEDICATION - 16 school days or more

- ~ Must meet all of the requirements for short-term medication PLUS ADDITIONAL DETAILED INSTRUCTIONS ARE REQUIRED FROM YOUR LICENSED HEALTH PROFESSIONAL.

**REMEMBER: MEDICATIONS OTHER THEN ORAL, EYE, EAR, OR TOPICAL MAY NEED TO BE ADMINISTERED BY A LICENSED NURSE: EPINEPHRIN AUTO INJECTORS (Epi-Pen, AV.Q) ARE AN EXCEPTION. PLEASE CONTACT YOUR SCHOOL NURSE FOR MORE INFORMATION.**

Thank you for your cooperation.

\_\_\_\_\_  
(School Nurse)

\_\_\_\_\_  
(Date)