Lake Washington School District #414
Health Services

MEDICATION ADMINISTRATION AUTHORIZATION AT SCHOOL

Student's Name: _____ Birthdate: _____

School: _____ Grade: _____

This section to be completed by Health Care Provider

ONE MEDICATION PER FORM

Medication: _____Strength:_____

Dose: _____Route:_____

Time to be given: _____ If PRN, length of time between doses:_____

If approved by school, can student self-carry and self-administer medication? YES: ☐ NO: ☐

Anticipated action of medication: _____

Possible side effects of medication: _____

Emergency procedure in case of serious side effects: _____

Diagnosis_____

I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated. There exists a valid health reason which makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials. Medication may be administered by non-licensed school personnel.

_____ _____
Health Care Provider Signature – NO STAMPS Date

_____ __(_____)_____
Printed Name Phone Number

This section is to be completed by Parent/Guardian

As the parent/guardian, I authorize the school to administer the medication to my student in accordance with the health care provider's instructions. This order is valid only for the current school year, which includes summer school. Medication must be supplied to the school in the original container.

_____ _____
Signature of Parent/Guardian Date

_____ __(_____)_____
Printed Name Phone Number