LUMMI NATION SCHOOL
Authorization for Medications at School

Student_____ Birthdate_____ Grade_____ Year_____

Medication will be administered by trained designated school personnel to a student at school only when absolutely necessary per RCW 28A.210.260-270 and RCW 18.71.030 (3). The school accepts no responsibility for unanticipated reactions when the medication is administered in accordance with the directions of the student's Health Care Provider. Orders must be nondiscretionary and legible.

This form should <u>not</u> be used to prescribe emergency medications or injections. **<u>ONLY ONE MEDICATION PER FORM</u>**

Section #1: To be completed by the PARENT/GUARDIAN

Please check only on box:

❑ I request that authorized staff administer the medication indicated in section #2. Health Care Provider's signature needed.

❑ I request that my child be allowed to **self-administer <u>prescription</u>** medication indicated in section #2. Health Care Provider's signature needed.

❑ I request that my child be allowed to **self-administer <u>over-the-counter medication</u>** (RCW 26.28.015 or RCW 70.02.130). Parent must sign below and complete medication information in section #2. No Health Care Provider signature is needed.

➢ **By signing this, I consent to exchange of information regarding this medication authorization between the school and the Health Care Provider. I have read and understand the information on page 2 of this form.**

_____ _____ _____
Date Parent/Guardian Signature Phone

Section #2: To be completed by the HEALTH CARE PROVIDER (or parent, if over-the-counter self-administered)

This medication will be: ❑ Staff administered ❑ Self-administered (student has demonstrated the skill level necessary)

Diagnosis/reason for medication_____

Name of medication_____ Dose to be given_____

☐ Oral (MDI, Nebulizer inclusive) ❑ Topical ❑ Eye drops ❑ Nasal ❑ Rectal ❑ Other:_____

Specific Time(s) _____AM _____PM and frequency of administration _____

_____

Possible side effects_____

Length of prescription: ❑ Current school year (including summer school) ❑ Other:_____

I request and authorize that the above-named student be administered or be allowed to self-administer the above-identified medication in accordance with the instructions indicated.

_____ _____
Licensed Health Care Provider signature Date

_____ _____
LHCP printed name Telephone number

PARENT/GUARDIAN INFORMATION REGARDING MEDICATIONS IN SCHOOL

I certify that I am the parent, legal guardian, or other person in legal control of this student. I request and authorize the school to administer the medication prescribed, as authorized by RCW 28. A210.260-270 and RCW 18.71.030 (3). This includes oral, inhaled, topical, nasal, rectal, eye and ear drops that shall be given at school **only when absolutely necessary**. Designated/trained employees shall administer this medication in compliance with Licensed Health Care Provider (LHCP) orders.

I understand the medication must be furnished in the **current, original container** from the pharmacy with the student's name, the name of the medication and the amount to be given. Non-prescription medication must be furnished in the original container from the manufacturer. All medication must be in a form ready to be administered and **must not** require any preparation by building staff. If the dosage or time should change, new orders and container will be provided.

I understand it is **the parents'** responsibility to deliver and maintain an adequate supply of the medication at school. The medication may not be delivered by the child or school bus driver. Medication delivered by the child or bus driver will NOT be dispensed.

I understand that it is the student's responsibility to come and receive his/her medication at the appointed time. I also understand that because of the school's schedule and other responsibilities of school staff members, there may be occasions in which a dosage may be delayed or missed.

I understand medication orders are only valid for the current school year (including summer school). Any medication remaining at the end of the school year, not picked up within 5 days after the last day of school, will be destroyed, with the exception of Extended School Year students.

As a general rule, the school will not administer prescribed medications during field trips. I understand that in those instances where medication must be administered I will make arrangements at least 24 hours prior to the field trip.

If self-administration is requested (and approved by principal/nurse), I certify that my child has the skill level necessary to do so, and that the school will assume no responsibility/liability for the administration of the medication or its use. Student may only carry a one-day supply of oral medication.

I have read the information above instructions and am in agreement with them.

_____ _____

Parent signature Date

_____ _____

Parent printed name Telephone number