



## AUTHORIZATION FOR MEDICATIONS TO BE TAKEN AT SCHOOL

The following section is to be completed by the PARENT/GUARDIAN:

(please print)

School _____	Grade _____	Birth Date _____
Student's Name _____ (Last)	_____ (First)	Sex _____
_____ (Health Care Provider's Name)	_____ (Address)	_____ (Phone)
<b>Please check only one box:</b>		
<input type="checkbox"/> 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.		
<input type="checkbox"/> 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>The Agreement of Exception to district policy and procedure (on the back of this form) must be signed by the parent(s) or guardians) and the health care provider.</i>		
<input type="checkbox"/> I 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: _____	
<input type="checkbox"/> Tablet/Capsule <input type="checkbox"/> Liquid <input type="checkbox"/> Inhaler <input type="checkbox"/> Injection <input type="checkbox"/> Nebulizer <input type="checkbox"/> Other _____		
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? <input type="checkbox"/> yes <input type="checkbox"/> no <i>If yes, must sign Agreement of Exemption on reverse of this form.</i>		
Length of time this treatment is recommended: _____		
<b>Detailed instructions (below) -- required for 16 school days or more.</b>		
Possible side effects: _____		
Emergency procedure in case of serious side effects: _____		

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

### AGREEMENT OF EXEMPTION

The parents/guardians 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 their child.

_____	_____	_____	_____
(Parent/Guardian)	(Date)	(School Principal)	(Date)
_____	_____	_____	_____
(Parent/Guardian)	(Date)	(School Nurse)	(Date)
_____	_____	" Student has been trained by health care provider and is safe to self-administer.	
(Health Care Provider)	(Date)		

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

- C 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

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

#### LONG TERM PRESCRIBED MEDICATION - 16 school days or more

- C Must meet all of the requirements for Short-Term medication PLUS ADDITIONAL DETAILED INSTRUCTIONS ARE REQUIRED FROM YOUR LICENSED HEALTH PROFESSIONAL.

**REMEMBER: ONLY ORAL MEDICATIONS CAN BE GIVEN BY NON-NURSE SCHOOL STAFF.  
EPI-PENS ARE THE ONLY EXCEPTIONS.**

Thank you for your cooperation.