# Hood Canal School District #404

## AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student's Name_____ Birthdate_____

School_____ Grade_____

**THIS PORTION TO BE COMPLETED AND SIGNED BY THE LICENSED HEALTH PROFESSIONAL IF IT IS NECESSARY TO DISPENSE MEDICATION DURING SCHOOL HOURS**

| Name of Medication | Dosage | Methods of Administration | Time of Day to be Taken |
|---|---|---|---|
| | | | |

If prn specify the length of time between doses:_____

Reason for medication to be given during school hours:_____

Permission to carry: INHALER: YES ☐ NO ☐ EpiPen: 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 medication in accordance with the instructions indicated above from _____ to _____. 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. Such medication may be administered by trained school personnel.

| Date of Signature | Signature of Licensed Health Professional | Name (Please print or type) |
|---|---|---|
| | | |

| Phone | FAX | Address | City | Zip Code |
|---|---|---|---|---|
| ( ) | ( ) | | | |

**THIS PORTION TO BE COMPLETED AND SIGNED BY THE PARENT/GUARDIAN**

*I certify that I am the parent, legal guardian, or other person in legal control of the above identified student. I request and authorize the school to administer the above identified medication to the above identified student in accordance with the prescription or instructions from a licensed health professional.*

**Medication must be supplied to the school in the original container, and the written authorization must match exactly the information on the container.**

I understand and agree that because of schedule and other responsibilities, a dosage or dosages may be delayed or missed. Permission granted to exchange medication information with the nurse.

| Signature of Parent or Legal Guardian | Date of Signature | Home Phone | Work Phone |
|---|---|---|---|
| | | ( ) | ( ) |

**Reviewed by School Nurse**_____ **Date**_____