

Central Valley School District #356
19307 E. Cataldo, Spokane Valley, WA 99016

AUTHORIZATION FOR ADMINISTRATION OF ORAL MEDICATION AT SCHOOL

Student Name: _____ Birthdate: _____

School: _____ Grade: _____

THIS PORTION TO BE COMPLETED BY LICENSED HEALTH PROFESSIONAL (LHP) WITH PRESCRIPTIVE AUTHORITY

Name of Medication	Dosage	Methods of Administration	Time of day to be taken

Diagnosis: _____

If given 'as needed' (prn), specify the length of time between doses: _____

May student carry inhaler on his/her person?*** Yes No

This student has demonstrated to a licensed health professional in my office the ability to correctly administer this medication.

Is student trained to self-administer emergency injectable medicine? 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 oral medication in accordance with the instructions indicated above from _____ to _____ (Not to exceed current school year), as there exists a valid health reason that makes administration of the medication advisable during school hours.

Date of Signature: _____ Licensed Health Professional's Signature: _____

Telephone #: _____ Fax #: _____ Print Name: _____

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I have reviewed the parent information regarding medication at school and request/authorize the school to administer medication to my student in accordance with the LHP's instructions for the period from _____ to _____ (not to exceed current school year). District Policy, 3416 AP, states that due to the schedule and other responsibilities, it is possible for a dosage(s) to be delayed or missed.

I will allow my student to carry his/her own inhaler: Yes No

My student may carry and is trained to self-administer his/her own emergency injectable medication: Yes No

The district shall incur no liability as a result of any injury arising from the self-administration of this medication.

Date of Signature: _____ Parent/Guardian Signature: _____

Home phone #: _____ Work/cell phone #: _____

This record must be kept for a period of 8 years

Student demonstrated appropriate self-usage of the inhaler/EpiPen to the School Nurse: Nurse signature: _____

Parent Information on Medication at School

Pursuant to the State of Washington laws, administration of oral medication may be provided at school if all conditions are met. District Policy, 3416AP, states that 'due to the schedule and other responsibilities, it is possible for a dosage(s) to be delayed or missed.' If a dose is delayed or missed, parents will be notified.

I All Medication

1. A signed '**Authorization**' form must accompany **all** medications.
2. Medications must be brought to the school office by the parent and **not the student**.
3. **Pills need to be broken prior to being brought to school for half dosages.**
4. Medication left at school shall be destroyed the last day of school, according to district policy.

II Prescription Medication

1. An '**Authorization**' form must be completed and signed by the **health care provider and parent**.
2. All medication must be in the **original prescription bottle** and properly labeled with the student's name, name of medication, exact dosage, name of health care provider, date and time of day to be given.
3. The directions of the 'Authorization' form **must match** the directions on the prescription bottle.
4. **Sample** medication must also be properly labeled and in the original container or package.
5. **Inhalers** - The health care provider **and** parent must state in writing on the 'Authorization' form if the student is to **carry** an inhaler. The school Nurse will also be part of this decision. **The school shall not be responsible for documentation of medication carried and self-administered by the student.**
6. **No more than a 20 (twenty) day supply of Schedules II-V medications** (i.e. Ritalin, cough syrup with codeine) should be brought to school by the parent.
7. All medications to be given by nebulizer must be provided in individual unit doses.

III Non-Prescription Medication (e.g. cough drops, vitamins, aspirin, cough syrup, or any over-the-counter medication)

1. An '**Authorization**' form must be completed and signed by the **health care provider and parent**.
2. **No medication** shall be given without this 'Authorization' form.
3. Non-prescription medication must be in the original package and **must be labeled by the parent**, with the student's name, name of health care provider, exact dosage and time of day to be given.

IV Over-the-counter Oral Medication to be self-carried – grades 9 through 12

1. A '**Permission**' form must be completed and signed by the **parent and principal or school nurse**.
2. Medication must be in the original labeled container.
3. Student will carry written permission from the parent indicating the name and dosage of the medication.

V Administering Medication 15 Days or Less

1. An '**Authorization**' form must be completed and signed by the **parent**.
2. The **health care provider** must write, on either a prescription blank or an 'Authorization' form, a request for medication to be administered at school.

VI Administering Medication 15 Days or More

1. An '**Authorization**' form must be completed and signed by the parent and health care provider.
2. This 'Authorization' form must contain complete physician instructions. A prescription blank is not sufficient for medications over 15 days.

VII Non-Oral Medication

1. School personnel will not administer eye drops, ointments, or topical medication. They must be self-administered by the student or they may be administered by a parent/guardian/or an adult designated by the parent who comes to the school for this purpose.
2. **Injectables – May only be given by a licensed nurse (available only on a few days/week at most buildings), the student, or a parent/guardian except as listed below:**
 - a. If a student is susceptible to a predetermined, life-endangering situation, trained school personnel may assist the student with an auto-injection, i.e. Epipen. The health care provider **and** parent must state in writing on the "Authorization" form if the student is to **carry** an Epipen.
 - b. The parents of a student with diabetes may authorize a Parent Designated Adult (PDA) who may or may not be a school district employee, to give injections and/or administer blood glucose monitoring. The PDA must receive additional training from a health care professional or expert in diabetic care selected by the parents.