

FERNDALÉ PUBLIC SCHOOLS
Ferndale, Washington

AUTHORIZATION FOR ADMINISTRATION OF ORAL MEDICATION AT SCHOOL

STUDENT _____ BIRTHDATE _____

SCHOOL _____ TEACHER _____

THIS PORTION TO BE COMPLETED BY STUDENT'S HEALTH CARE PROVIDER

Medication will be given to a student at school only when absolutely necessary. The parent and licensed health care provider are urged to design a schedule for giving medication outside of school hours. If this is not possible, the medication will be given by designated school personnel employed by the District in order to accommodate the student's individual needs. Only oral medication will be administered.

The school accepts no responsibility for untoward reactions when the medication is dispensed in accordance with the directions of the student's licensed health care provider. Orders must be nondiscretionary and legible. **ONLY ONE MEDICATION PER FORM**

Name of Medication: _____
Strength of Tablets: _____ mg. # of Tablets _____ Total Dosage _____ mgs.
Inhalers/Dosage: _____
Time(s) of Dosage: _____
Anticipated action of Medication: _____
Length of Prescription Period: From _____ To _____
Possible side effects: _____
Emergency measures in case of serious side effects: _____

I certify that valid health reasons exist requiring that the medication be administered during school hours or during such time that the student is under supervision of school officials.

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

Date of Signature

Licensed Health Care Providers Signature

Telephone Number

NAME (Print or Type)

Parent/Guardian portion to be completed on back of form.

OVER ⇒

THIS PORTION OF FORM IS TO BE COMPLETED 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 have read this form and Guidelines for Parent/Guardian Regarding Oral Medications in School and request and authorize the school to administer the medication prescribed.

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.

It is the parent's responsibility to deliver and maintain an adequate supply (not more than a one month supply) of the medication at school. The medicine may not be delivered by the child or school bus driver. Medication delivered by child or bus driver will NOT be dispensed.

I understand that my signature indicates that the school accepts no liability for untoward reactions when the medication is administered in accordance with the physician's directions.

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 the other responsibilities of school staff members, there may be occasions in which a dosage may be delayed or missed.

If there is any medication left at the end of the school year, it will be destroyed if I do not pick it up within 5 working days after school is out.

Parent/Guardian Signature: _____ Date: _____

Telephone Number: _____ / _____
HOME WORK