AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN STEVENSON-CARSON SCHOOL DISTRICT

Student's Name:_____ Allergies: _____

DOB: _____ Gr: _____ School: _____ School Year: _____

THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH PROVIDER (LHP)

Name of Medication:_____

Dosage/Frequency: _____

If given PRN, specify the length of time between doses: _____

Diagnosis or reason for medication:_____

Further instructions (possible reactions, etc.):_____

Student is capable of self-carrying/administering Asthma, Anaphylaxis & Diabetes medication? ☐ Yes ☐ NO

BACKUP MEDICATION KEPT IN HEALTH ROOM IS HIGHLY ENCOURAGED!

I request and authorize that the above-named student be administered the identified medication in accordance with the instructions indicated above from_____to_____(not to exceed current school year), as there exists a valid health reason which makes administration of the medication advisable during school hours.

Licensed Provider Signature	Clinic Name	Date
Name (Print or type)	Telephone	Fax

THIS PORTION TO BE COMPLETED BY THE PARENT/LEGAL GUARDIAN

I request and authorize the school to administer medication to the above identified student in accordance with the health care provider's instructions.
My signature indicates that I understand the district shall incur no liability as a result of any injury arising from the self-administration of medication by the student and parent/legal guardian shall hold harmless the district and its employees or agents against any claim arising out of the self-administration of medication by the student (WSVSD policy 3416).

You have my permission to communicate with this health care provider in order to make arrangements for the care and supervision of my child. I also give the Health Care Provider:

Permission to fax this form to the school: ☐ Yes ☐ No
Permission for my student to self-carry and self-administer Asthma, Anaphylaxis & Diabetes Medication?: ☐ Yes ☐ No

Parent/Legal Guardian Signature	Date of Signature

Please note:

Reviewed by: _____
School Nurse/Date

1. All prescribed medication must be provided in a pharmacy labeled container (matching the provider's order) with the name of your student, name of the medication, and the dosage and frequency in which the medication is to be given.
2. Over the counter medications must have an authorization from a health care provider and be in the original container.
3. Medications must be brought to the school by the parent/guardian.
4. No more than a 20 day supply may be kept at school.
5. If your student's medication is needed during a field trip, you must bring a single dose of the medication in a separate container/bottle labeled by a pharmacist. You can request this from your student's pharmacy. Please bring this to school at least 3 days before the scheduled field trip.

PLEASE SEE BACK PAGE FOR INSTRUCTIONS

If your student requires medications at school,
please refer to the following instructions:

1. Notify your school nurse right away. If medication is needed for a life-threatening condition, the nurse may need to work with parent to create a care plan. Direct school numbers can be located on the district website at http://www.scsd303.org/ and are listed below.
2. Please complete parent section of the medication authorization form and provide student details at the top of the form.
3. Send to healthcare provider to complete and sign. If multiple medications needed at school, please fill out one form for **each** medication.
4. You or your provider may fax completed medication authorizations to your child's school.
5. Return form(s) with medication to school **before the first day of school.**
6. Contact nurse with any further questions or concerns.

School Contacts:

District Office (509) 427-5674 Fax: (509) 427-4028	Stevenson Elementary School (509) 427-5672 Fax: (509) 427-7413
Stevenson Carson Preschool (509) 427-5672 Fax: (509) 427-7413	Carson Elementary School (509) 427-5939 Fax: (509) 427-5874
Wind River Middle/Stevenson High School (509) 427-5631 Fax: (509) 427-5639	