Lake Washington School District #414
Health Services

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student's Name: _____ Birthdate: _____

School: _____ Grade: _____

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This Portion to be Completed by Health Care Provider/ Dentist

Name of Medication	Strength	Dosage	Method of Administration	Time of Day To Be Given

Diagnosis _____

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

Indicate if student will self carry inhaler/epipen on his/her person Yes ☐ No ☐

Anticipated action _____

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. Medication orders are good for the current school year only, which includes summer school. 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. ***Medication may be administered by non licensed school personnel.***

_____ _____
Health Care Provider/ Dentist Signature Date of Signature

_____ _____
Printed Name Phone Number

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This Portion of the Form Is To Be Completed By 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 health provider's prescribed instructions, not to exceed the current school year which includes summer school.

Medication must be supplied to the school in the original container

_____ _____
Parent/ Guardian's Signature Date of Signature

_____
Phone Number: Home/Work (indicate area code)

Form 4023

WHITE: Keep with medication (school copy) **YELLOW:** Nurse Revised: 5/11