

Mount Vernon School District
124 E. Lawrence Street
Mount Vernon, WA 98273

School Building Fax # _____ (if authorization is faxed, original must be mailed to the school)

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student Name: _____ Birth Date: _____ Sex: M / F

School: _____ Teacher: _____ Grade: _____

HEALTH CARE PROVIDER completes this section: *(please print)*

I have determined that the medication named below is necessary during the school day.

Name of medication: _____ Dose: _____

Tablet/Capsule Liquid Inhaler Nebulizer Other _____

If medicine is given DAILY, at what time? _____

If medicine is to be given AS NEEDED, describe indications: _____

How soon can it be repeated? _____

Is child allowed to carry and self-administer "rescue inhaler"? Yes No

If **yes**, I have trained this student in the purpose and appropriate method and frequency of use.

Storage Instruction: Room Temperature Refrigeration

Diagnosis or reason for medication: _____

Length of time this treatment is recommended: Current School Year From _____ To _____

Significant side effects: _____

Date: _____ Health Care Provider Signature: _____

Phone #: _____ Print Name: _____

Fax #: _____ Address: _____

PARENT/GUARDIAN completes this section:

I request that my child be allowed to take the medication as described above.

I understand that school staff will attempt to administer medication in a timely manner, however, due to school's schedule and other responsibilities of school staff members, it is permissible for dosage or dosages to be delayed or missed.

I will provide the medication in the original, properly labeled container.

I understand that if I do not pick up any medication left at the end of the school year, it will be destroyed.

I give my permission for school staff to communicate freely with this health care provider.

I understand that my signature indicates my understanding that the school staff shall not incur any liability for any injury when the medication is administered in accordance with the health care provider's direction and in accordance with the District Policy and Procedure 3416 and 3419.

(Date)

(Parent/Guardian Signature)

(Daytime Phone)

(Emergency Phone)

6/06
