LEWIS COUNTY ADVENTIST SCHOOL

MEDICATION ORDER FORM - Authorization for Administration of Medication at School

Student Name:_____ DOB:_____ Student ID: _____

School: _____ Grade: _____

THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH CARE PROVIDER

Name of Medication:	Diagnosis	Dosage & Route	Time	Specific Instructions and/or side effects to be expected:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If given 'as needed' specify length of time between doses: _____

Emergency procedure in case of serious side effects: _____

_____Yes _____No - Licensed Health Care Provider/designee has instructed student on correct use of inhaler or medication.

_____Yes _____No - Student has demonstrated to health care provider/designee necessary skills to administer life saving medication by self and student can carry medication.

_____Yes _____ No – Student in grade 9-12 is authorized to self-carry non-controlled prescription medication.

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

Health Care Provider's Signature: _____ Date: _____

Print Name: _____ Phone _____ Fax _____

Please note: **MEDICATION MUST BE PROVIDED BY THE PARENTS IN THE ORIGINAL CONTAINER WITH INSTRUCTIONS. If samples of medication are to be given, they must be labeled with the name of the student, dosage, and time to be given.**

THIS PORTION TO BE COMPLETED BY THE PARENT /GUARDIAN
(please print)

School: _____ Grade: _____ Birth Date: _____

Student's Name: _____

Parent/Guardian Name: _____

Cell/Work Phone: _____ Emergency Contact/Phone: _____

Please check appropriate box(es):

☐ I request that authorized persons at school administer to my student the medication(s) described. I also give my permission for exchange of information between the school district staff and the health care provider.

_____ _____ _____ _____
Parent/Guardian Signature Date School Nurse Signature Date

☐ I request that my child be allowed to self-carry/self administer **life saving medication (grades K-8) or non-controlled prescription (grades 9-12)**. I also give my permission for exchange of information between the school district staff and the health care provider. The Agreement of Exemption to district policy and procedure below must be signed by the parent(s) or guardian(s).

AGREEMENT OF EXEMPTION

The parents/guardians shall hold harmless and indemnify the school officers, employees and agents against all claims, judgments or liabilities arising out of the self-administration and carrying of medication to their child.

_____ _____ _____ _____
Parent/Guardian Signature Date School Nurse Signature Date

☐ I am a student eighteen (18) or older signing this form on my own behalf (RCW 26.28.015 or RCW 70.02.130). I also give my permission for exchange of information between the school district staff and the health care provider.

_____ _____
Student Signature Date