

Bellevue School District
Bellevue, Washington

AUTHORIZATION FOR MEDICATIONS TO BE TAKEN AT SCHOOL

The following section is to be completed by the PARENT/GUARDIAN: (please print)

| | | | |
|---|---------------------------------|------------------|-----------------------|
| Student's Name: _____ | | Sex: _____ | |
| _____ Last | _____ First | | |
| School: _____ | Grade: _____ | Birthdate: _____ | |
| Health Care Provider's Name | | Address | Phone |
| I request that the authorized persons at school assist my child in taking the medicine(s) described below or that my child be permitted to mediate herself/himself. I also give my permission for exchange of information between the school district staff and the health care provider. I understand that the medication is to be furnished by me in the original container labeled by the pharmacy or prescriber with the name of the medication, the amount to be taken, frequency of administration, and name of prescriber. | | | |
| _____ Date | _____ Parent/Guardian Signature | _____ Home Phone | _____ Emergency Phone |

The following section is to be completed by the HEALTH CARE PROVIDER: (please print)

| | |
|---|------------------------------------|
| Diagnosis for which medication is given: _____ | |
| Name of medicine: _____ | Dose: _____ |
| <input type="checkbox"/> Tablet/Capsule <input type="checkbox"/> Liquid <input type="checkbox"/> Inhaler <input type="checkbox"/> Injection <input type="checkbox"/> Nebulizer <input type="checkbox"/> Other _____ | |
| If medicine is to be given DAILY , at what time? _____ | |
| If medicine is to be given WHEN NEEDED , describe indications: _____ | |
| _____ | |
| How soon can it be repeated? _____ | |
| Is child authorized to medicate himself/herself? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| If yes, I have instructed this student in the purpose and appropriate method or frequency of use. | |
| List significant side effects: _____ | |
| _____ | |
| Length of time this treatment is recommended: _____ | |
| Other information: _____ | |
| _____ | |
| _____ | |
| Date: _____ | Health Care Provider's Name: _____ |
| Health Care Provider's Signature: _____ | |

Bellevue School District 405
Policy 4320

6.0 Administration of oral medication

In the event that there exists a valid health reason which requires the involvement of school personnel in the administration of any medication to a student during school hours or the hours in which the student is under the supervision of school officials, the following procedures shall apply consistent with RCW 28A.210.260 and the Washington State Nurse Practice Act.

6.1 Written authorization. A prior written request and authorization from the parent or guardian and the prescribing physician or dentist must be on file for the following categories of medication. Such requests and authorizations will be effective for the current school year unless a shorter period is specified.

6.1.1 Over-the-counter medication.

6.1.2 Prescription medication.

6.1.3 Epinephrine injection to prevent allergic reactions.

6.2 Persons who may administer

6.2.1 School nurses

6.2.2 Any employee trained and supervised by a school nurse improper procedures for administration of medication

6.3 Identification and security of medication

6.3.1 All prescription medication must be in the original pharmacy container labeled with the following information:

6.3.1.1 Name of student

6.3.1.2 Name of medication

6.3.1.3 Dosage and mode of administration

6.3.1.4 Name of physician prescribing medication

6.3.2 Nonprescription medication must be in the original retail container.

6.3.3 All medication must be kept in a locked secure place.

6.4 Record of administration

The administration of any dose of medication must be recorded on an individual medication log sheet.