WOODLAND SCHOOL DISTRICT NO. 404
AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

WOODLAND
Public Schools

Student's Name: _____ School: Woodland School District

Date of Birth: _____Grade: _____ Fax #: (360) 841-2801

THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH PROFESSIONAL (LHP)
PRESCRIBING WITHIN THE SCOPE OF THEIR PRESCRIPTIVE AUTHORITY

Name of Medication:_____

Dosage/Frequency: _____

Diagnosis or reason for medication: _____

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

Possible side effects of medication: _____

Student is capable of carrying/self-administering inhaler: _____ Yes _____ No _____ N/A
Student is capable of carrying/self-administering epipen: _____ Yes _____ No _____ N/A

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

_____ _____
Licensed Health Professional signature **Date of signature**

_____ _____
Name (Print or type) **Telephone / Fax**

Please note:

1. **Prescribed medication must be provided in the container labeled by the pharmacist with the name of the child, the name of the medication, the dosage and frequency in which the medication is to be given.**
2. **All medications must be transported to the school office by a parent.**
3. **Over the counter medications must be a new, unopened supply.**
4. **If medication samples are to be given, they must be labeled with the student's name, dosage, and time to be given.**

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I request and authorize the school to administer medication to the above identified student in accordance with the health care provider's instructions. I understand that every reasonable effort will be made by school staff to administer the medication in a timely manner. Because of the schedule and other staff responsibilities, it is permissible for a dose or dosage to be delayed or missed (School Board Policy/ Procedure 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 give the health care provider permission to fax this form to the school: _____Yes _____No
Permission to carry & self-administer inhaler (if authorized by LHP) _____Yes _____No ____ N/A
Permission to carry & self-administer epipen (if authorized by LHP) _____Yes _____No ____ N/A

Parent/Guardian signature: _____ Date: _____

Parent/Guardian phone #: _____ Cell or Work phone #: _____