MEDICATION AUTHORIZATION ORDER

Student Name:		DOB:
School:	Student #:	Grade:

GUIDELINES FOR MEDICATION AT SCHOOL

All medication should be dispensed before or after school hours by the parent/guardian. Medication should be given at school only when absolutely necessary. Whenever possible the parent/guardian and licensed health care provider (LHCP) are urged to design a schedule for giving medication outside of school hours. Medication is defined as any medication prescribed or non-prescribed; including over-the-counter items (OTC), vitamins, homeopathic remedies, creams, and/or oils.

If a student ***must*** receive prescribed **medications** during school hours or when the student is under the supervision of school officials, the following procedures must be followed. Prescribed or non-prescribed (OTC) medication may be dispensed to students on a scheduled basis once a completed Medication Authorization Order, signed by a LHCP and parent/guardian is on file. The request is valid for the current academic school year, including summer school, unless a shorter time period is specified. The medication, supplied by the parent/guardian must be in the original, properly labeled container to include any over the counter medication and samples. Everett Public Schools accepts no responsibility for adverse reactions when the medication is dispensed in accordance with the LHCP order. Reference Board Policy 3416.

MEDICATION ORDER – TO BE COMPLETED BY LHCP

Diagnosis	Medication	Dosage	Route	Time/Interval/ Condition/Symptom	Side Effects

Quick Relief Inhaler Medication Orders: Inhaler Medication: _____

- Inhale _____ puffs by mouth every _____ hours. May repeat dose _____ times.
- If symptoms persist, repeat dose after _____ minutes. May repeat dose _____ times.
- May also inhale _____ puffs _____ minutes prior to physical activity as needed.

LHP SIGNATURE/ INFORMATION

I have prescribed and request the above-named student receive the above-identified medication(s) for use during school hours and school sponsored events and have instructed the student in the correct and responsible use of the medication(s) per RCW 28A.210.370 beginning with the _____ day of_____, 20_____ (not to exceed the current school year).

LHCP Signature:		Date:
LHCP Printed Name:	LHCP Phone:	LHCP Fax:

THIS PORTION TO BE COMPLETED BY PARENT/GUARDIAN

- Due to unforeseen circumstances, I understand a dose may be delayed or missed.
- All medications must be in their original, properly labeled container with instructions matching the Medication Authorization Order.
- When notified by school personnel that medication remains after the course of treatment, I will collect the medication from the school or understand that it will be destroyed.
- Everett Public Schools assumes no responsibility for self-carried medications.
- My signature below indicates that I have read and understand and will abide by the district medication Policy 3416.

LEVEL OF SELF CARE

❑ **YES***, student **MAY** always self-carry and self-administer medication(s) during the school day.
❑ **YES***, student **MAY** always self-carry medication(s), but **MAY NOT** self-administer medication(s).
❑ **NO,** student **MAY NOT** self-carry medication(s), it will be stored in the health room.
***Marking "yes"** indicates that student has been thoroughly instructed in the purpose and appropriate method/frequency of use and/or safe carrying of medication(s) and that student/parent/guardian understand the responsibilities of self-carrying at school*

➢ Parent/Guardian Printed Name and Signature:	Date:
➢ Student Signature: Only if authorized to self-carry	Date:

Internal use only:

- Student has demonstrated the skill level necessary to use medication(s) or device as prescribed above and is authorized to self-carry medication(s) at school: ❑YES ❑ NO
- Student may self-manage medication(s): ❑YES ❑ NO

District RN Signature:_____ Date: _____