EVERETT PUBLIC SCHOOLS

MEDICATION AUTHORIZATION ORDER FORM

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

Guidelines for Medications at School

All medication should be dispensed before and/or after school hours by the parent or 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 **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 Form, 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 School Policy 3416.

MEDICATION ORDER
To be completed by the LHCP

Diagnosis	Medication	Dosage	Route	Time/Interval/ Condition/Symptom	Self-carry Select One	Side Effects
					Yes* / No	
					Yes* / No	
					Yes* / No	
For Inhaler Medication Orders Only: Inhaler Medication: _____ •Inhale_____ puffs by mouth every ____hours as needed. •If symptoms persist, repeat _____ puffs after _____ minutes. May repeat dose _____ times. •May also inhale _____ puffs _____minutes prior to physical activity as needed.					**Yes* / No**	

*Marking "Yes" indicates that the LHCP has provided instruction in the purpose and appropriate method/frequency of use, and the student is capable and safe to self-carry and administer prescribed medication(s).

LHCP SIGNATURE/ INFORMATION

I request and authorize that the above-named student receive the above-identified medication(s) in accordance with the instructions indicated, beginning with the day ____of ____, 20_____ (not to exceed the current school year). There exists a valid health reason, which makes administration of the medication advisable during school hours.

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 Form.
- 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.

➢ Parent/Guardian Printed Name and Signature:		Date:
Home Phone #:	Work #:	Mobile #:
➢ Student Signature: Only if authorized to self-carry		Date:

District RN Signature: _____ Date: _____