Vale Fax 509 782-1214 CMS Fax 509 782-2547 CHS Fax 509 782-289

Cashmere School District - Authorization for *MEDICATION* at School

Student Name:		**DOB:**		**Grade:**	

THIS PORTION MUST BE COMPLETED BY THE PHYSICIAN / DENTIST

Name of Medication	***Dosage***	***Route***	***Time of Day***	***Time Interval if PRN***

Student 1) MUST carry inhaler or medication on his/her person? _____ YES _____ NO ***and*** 2) Student has been instructed on inhaler use by the HCP and is capable of self-administration of medication _____ YES _____ NO

Initial of HCP

Reason for medication to be given during school hours _____

Anticipated action _____

Possible side effects of medication _____

Emergency procedure in case of serious side effects _____

Medications student is allergic to _____

Does student take any medication at home that prevents serious health risks? _____ YES _____ NO

If yes, please describe: _____

I request and authorize the above named student be administered this medication according to the instructions indicated above from __/__/__ to __/__/__ as there exists a valid health reason which makes the administration of the medication advisable during school hours or during such time the student is under the supervision of school officials. Such medication may be administered by medication trained school personnel.

Print Name: _____ LHCP Signature: _____

Telephone: _____ Office Fax: _____ Date: _____

Please Note: *If samples of medication are given, they must be labeled with the name of the student, dosage and time to be given. RCW 28A.210.260*

THIS PORTION OF THE FORM IS TO BE COMPLETED BY PARENT / GUARDIAN

I certify that I am the parent, or legal guardian in legal control of the above identified student and request and authorize the school to administer the above identified medication to the above identified student in accordance with the prescription, or LHCP's instructions, for the period from ___/___/___ to ___/___/___ (not to exceed one school year).

I understand the district policy on administration of medication at school and am in agreement to its content. Medication must be in the original container labeled with instructions on how it will be given at school. I understand that every effort will be made by the school staff to administer the medication in a timely manner and accept that at times the doses of medication may be delayed or missed due to conflicts in the student's schedule or other responsibilities of school personnel. I give my consent to release the above identified student for further medical or hospital care in the event of an emergency. I give my consent for school district staff to exchange information with the above HCP and associated school staff, regarding the above student for the duration of the school year.

_____ _____ _____ _____

Parent/Guardian Signature Date Cell Other phone

Student has demonstrated to school nurse correct administration of inhaler: (school nurse signature) _____