MERIDIAN SCHOOL DISTRICT

Fax: 360-318-2197
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AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

SCHOOL YEAR: _____

STUDENT NAME: _____ **DOB:** _____ **GRADE:** ____ **SCHOOL:** _____

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

PRESCRIBER INFORMATION

LICENSED PRESCRIBER'S NAME: _____

BUSINESS PHONE: _____ **FAX:** _____

MEDICATION INFORMATION

NAME OF MEDICATION: _____ **DOSAGE:** _____
TIME(S) TO BE GIVEN: _____ ☐ **ORAL** ☐ **INJECTED** ☐ **INHALED** ☐ **OTHER:** _____
START DATE: _____ **END DATE:** _____ *NOT TO EXCEED THE SCHOOL YEAR

NAME OF MEDICATION: _____ **DOSAGE:** _____
TIME(S) TO BE GIVEN: _____ ☐ **ORAL** ☐ **INJECTED** ☐ **INHALED** ☐ **OTHER:** _____
START DATE: _____ **END DATE:** _____ *NOT TO EXCEED THE SCHOOL YEAR

DIAGNOSIS OR REASON FOR MEDICATION(S): _____

IF GIVEN, PRN, SPECIFY LENGTH OF TIME BETWEEN DOSES: _____

INHALERS: _____ **STUDENT CARRIES:** ☐ **YES** ☐ **NO**

STUDENT IS CAPABLE OF SELF ADMINISTRATION OF MEDICATION: ☐ **YES** ☐ **NO** *STUDENTS ARE NOT ALLOWED TO SELF-ADMINISTER CONTROLLED SUBSTANCES

POSSIBLE SIDE EFFECTS OF MEDICATION: _____

EMERGENCY PROCEDURE IN CASE OF SERIOUS SIDE EFFECTS: _____

I request & authorize that the above-named student be administered the above identified medication in accordance with the instructions indicated above, as there exists a valid health reason which make administration of the medication advisable during school hours.

_____ _____
SIGNATURE OF LICENSED HEALTH PROFESSIONAL DATE

PARENTAL CONSENT

THIS PORTION TO BE COMPLETED BY THE STUDENT'S PARENT/GUARDIAN

- **I REQUEST/AUTHORIZE THE MERIDIAN SCHOOL DISTRICT TO ADMINISTER MEDICATION TO THE ABOVE IDENTIFIED STUDENT IN ACCORDANCE WITH THE LHP'S INSTRUCTIONS:** ☐ **YES** ☐ **NO**
- **I GIVE PERMISSION FOR MY CHILD TO SELF-ADMINISTER MEDICATION IF THE SCHOOL NURSE DETERMINES IT IS SAFE AND APPROPRIATE:** ☐ **YES** ☐ **NO** *STUDENTS ARE NOT ALLOWED TO SELF-ADMINISTER CONTROLLED SUBSTANCES
- **I GIVE PERMISSION FOR MY CHILD TO CARRY AN INHALER:** ☐ **YES** ☐ **NO**
- **I GIVE PERMISSION FOR MY CHILD TO CARRY THEIR MEDICINE:** ☐ **YES** ☐ **NO**

_____ _____ _____
PARENT/GUARDIAN NAME PARENT/GUARDIAN SIGNATURE DATE

_____ _____
HOME PHONE WORK/CELL PHONE