



**EDMONDS SCHOOL DISTRICT
AUTHORIZATION FOR ADMINISTRATION OF
ORAL AND AUTO-INJECTABLE MEDICATION* AT SCHOOL**

Student's Name _____ Birthdate _____

School _____ Grade _____

Medication is ordered to be given to a student at school only when absolutely necessary.

**THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH PROFESSIONAL (LHP)
(e.g., MD, DO, ARNP, DDS, etc.)**

NAME OF MEDICATION	DOSAGE	METHODS OF ADMINISTRATION	TIME OF DAY TO BE TAKEN

Diagnosis or reason for medication: _____

If given PRN, specify the length of time between doses and signs of when to give: _____

Possible side effects of medication: _____

Emergency procedure in case of serious side effects: _____

**Note: Auto-Injectable Medications may only be administered to students with potential for severe allergic and/or life-threatening reactions.*

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

LHP's Signature: _____ Date: _____

LHP's Name: _____ Phone Number: (____) _____

LHP's Address: _____ Fax Number: (____) _____

PARENT/GUARDIAN PERMISSION

The medication is to be furnished by me in the original container, labeled by the pharmacy with the name of the medicine, amount to be taken, and the time of day to be taken. The Licensed Health Professional's name is on the label. I understand that my signature indicates my understanding that reasonable care will be exercised in administration of the medication. The school accepts no responsibility for adverse reactions when the medication is dispensed in accordance with the licensed health professional's directions. If medication remains after the course of treatment, I will collect the medication from the school or understand that it will be destroyed.

Signature of Parent/Guardian: _____ Date: _____

This authorization is good for the current school year only

(over)

**EDMONDS SCHOOL DISTRICT NO. 15
LYNNWOOD, WA 98036-7400
Educational Health Services**

ADMINISTRATION OF MEDICINES AT SCHOOL

**PROCEDURE FOR PARENT/GUARDIAN TO FOLLOW IF IT IS ESSENTIAL THAT
STUDENT RECEIVE MEDICATION DURING TIME OF ATTENDANCE AT SCHOOL
AND STUDENT NEEDS HELP FROM STAFF:**

1. Have your licensed health professional complete the front page of this form (H-145) Authorization for Administration of Oral Medication at School (formerly Physician's Authorization for Medication at School). Return it to school. Instructions must be specific and not depend on school staff judgment.
2. Provide medication in a container with the original label from the licensed health professional or pharmacist. The label must have your child's name, the name of the medication, dosage and time of administration.
3. To prevent unsupervised access of your child or other students to the medication, personally deliver it to the school. Have staff in the health room count the number of pills and document on the Medication Receipt form (H-141).
4. You will want to maintain a record of the use of long-term medication so that you will know when to replenish the school supply.
5. The quantity at school can be up to a month supply.