Concrete School District No. 11
45389 Airport Way, Concrete, WA 98237
Concrete Elementary School Fax No.: (360) 853-4149

AUTHORIZATION FOR MEDICATIONS TO BE TAKEN AT SCHOOL

The following section is to be completed by the PARENT/GUARDIAN: (please print)

School _____ Fax # _____ Grade _____

Student's Name _____ _____ Initial _____
(Last) (First)

Birth Date _____ ID # _____ Gender _____

_____ _____ _____
(Health Care Provider's Name) (Address) (Phone & Fax)

Please check only one box:

☐ I request that authorized persons at school assist my child in taking the medicine(s) described below. I also give my permission for exchange of information between the school district staff and the health care provider.

☐ I request that my child be allowed to self-administer medication. I also give my permission for exchange of information between the school district staff and the health care provider. I shall hold harmless and indemnify the school and Concrete School District's officers, employees, and agents against all claims, judgments, or liabilities arising out of the self-administration and carrying of medication by my child.

☐ I am signing this form on my own behalf (RCW 26.28.015 or RCW 70.02.130). I also give my permission for exchange of information between the school district staff and the health care provider.

_____ _____ _____ _____
(Date) (Parent/Guardian/Student Signature) (Home Phone) (Emergency Phone)

The following section is to be completed by the HEALTH CARE PROVIDER: (please print)

I have determined that the medication named below is advisable during the school day.

Diagnosis for which medication is given: _____

Name of medicine: _____ Dose: _____

☐ Tablet/Capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other _____

If medicine is to be given DAILY, at what time? _____

If medicine is to be given WHEN NEEDED, describe indications: _____

_____

How soon can it be repeated? _____

Is child authorized to medicate himself/herself? ☐ yes ☐ no

If "yes", student has been trained by health care provider and is safe to self-administer. ☐ yes ☐ no

Length of time this treatment is recommended: _____

Possible side effects: _____

Emergency procedure in case of serious side effects: _____

Date: _____ Health Care Provider's Signature: _____

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CONCRETE SCHOOL DISTRICT ORAL MEDICATION POLICY

1. An oral medication form must be completed for each medication, PRESCRIPTION OR NON-PRESCRIPTION. (These forms are available at school and doctor's offices).

2. The oral medication form is for the current school year only.

3. The oral medication form must be completed by both the PARENTS AND PHYSICIAN OR DENTIST before medication can be given at school.

4. There must be a valid health reason which makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials.

5. Medication must be supplied in the original container.

6. The medication and completed oral medication forms are to be brought to school by the parent.

MEDICATION WILL NOT BE GIVEN AT SCHOOL UNLESS THE ABOVE CONDITIONS HAVE BEEN MET.