Medication Authorization

Tonasket School District- **ES- 486-4933/TMS 486-2147/THS 486-2161**

Student Name: _____ Birth Date: _____

School: _____ Grade: _____

Student's Healthcare Provider *to complete this section*

Doctor/Healthcare provider please complete this section using one form for each medication

Diagnosis or reason for medication: _____

Severity of the problem: ❑ mild ❑ moderate ❑ severe

Activity modifications or restrictions: _____

Name of Medication	Dosage	Method of administration	Time to be given or frequency if PRN

If given PRN, describe indications: _____

Possible side effects of medication:_____

For EpiPens, describe signs or symptoms when to use: _____

Can the student travel on field trips > 30 minutes away from emergency medical response? ❑ yes ❑ no

Student has been instructed in the correct way to use this medication. ❑ yes ❑ no

Student has demonstrated the skill level necessary to use the medication appropriately without supervision. ❑ yes ❑ no

Student may carry and self-administer the medication ordered above. ❑ yes ❑ no

I request and authorize that the above-named student be administered or self-administer this oral medication according to the instructions indicated above from ___/___/___ to ___/___/___ (not to exceed current school year) as there exists a valid health reason which makes administration of the medication advisable during school hours.

_____ _____

Date of Signature ***Licensed Health Professional***

_____/_____ _____

Phone *FAX* *Name (Print)* *Clinic*

PARENT or GUARDIAN
To complete this section

I request and authorize the school to administer medication to the above student in accordance with the LHP's instructions for the period from ___/___/___ to ___/___/___ (not to exceed the current school year). I understand that information about this medication and health problem will be shared with school staff that need to know.

My child can carry and self administer this medication at school ❑ yes ❑ no

If I give permission for my child to carry and self-administration medication, I understand and agree that the district shall incur no liability as a result of any injury arising from the self-administration of medication by the student and I hold harmless the district and its employees or agents against any claims arising out of the self-administration of medication by the student.

_____ _____

Date of Signature *Parent/Guardian Signature*

_____ _____

Home Phone *Work or Cell Phone*

Reviewed by TSD RN : _____on ____/___/___