Mount Vernon Schools
124 East Lawrence Street
Mount Vernon, Washington

3415F.6
(Rev. 03/10/03)

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student Name_____ Birth Date_____

School_____ Grade_____

THIS PORTION TO BE COMPLETED BY THE PHYSICIAN/DENTIST

Medication will be given to a student at school only when absolutely necessary. Whenever possible, the parent and physician/dentist are urged to design a schedule for giving medication outside of school hours. If this is not possible, it must be understood that the medication will be given by building administrators, school secretaries, or licensed health professionals employed by the district.

The school accepts no responsibility for untoward reactions when the medication is given in accordance with the directions of the student's physician/dentist.

Name of Medication:_____ Dosage:_____

Time to be given:_____ Method of Administration:_____

Inhalers: Self administer? Yes___ No___

Storage Instructions: _____ Room Temperature _____ Refrigeration

Reason for Medication:_____

Length of Prescription Period: From _____ To_____

Possible Side Effects of Medication:_____

Directions for follow up after administration of emergency medication (Epi-Pen): _____

_____

I certify that a valid health reason exists requiring that the medication be administered during school hours or during such time that the student is under supervision of school officials.

I request and authorize that the above-named student be administered the above-identified medication in accordance with the instructions indicated. I will be monitoring the ongoing health status of this patient.

_____ _____

Physician's/Dentist's Signature Date

(We recommend that P.A. orders be countersigned by supervising physicians.)

THIS PORTION TO BE COMPLETED BY PARENT OR GUARDIAN

I certify that I am the parent, legal guardian, or other person in legal control of the above-named student. I have read this form, and request and authorize the school to administer the medication prescribed. The medication is to be furnished by me in the ORIGINAL prescription container.

I understand that my signature indicates that the school accepts no liability for untoward reaction when the medication is administered in accordance with the physician's/dentist's directions. I also agree that because of the school's schedule and other responsibilities of school staff members, it is permissible for dosage or dosages to be delayed or missed. If there is any mediation left at the end of the school year, it will be destroyed if I do not pick it up by the last school day. You have my permission to communicate freely with this physician/dentist.

_____ _____

Parent's/Guardian's Signature Date