AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student name:_____ Birthdate: _____School:_____ Gr:_____

THIS PORTION TO BE COMPLETED BY THE PHYSICIAN/HEALTH CARE PROVIDER

Name of Medication	Dosage	Method of administration	Time of day to be taken
Epi-pen		Intramuscular	PRN

If given "PRN" specify the length of time between doses: IF GIVEN, CALL 911

Diagnosis and reason for medication to be given during school hours: allergic reaction

Anticipated action: to help with breathing if allergic reaction

Possible Side effects of medication: increased Heart rate, tremors

Emergency procedure in case of serious side effects: call 911

Student may carry and/or self-administer this medication during school hours: ____YES __ __NO

SELF ADMINISTRATION OF MEDICATION AUTHORIZITION/APPROVAL

I request and authorize the school to administer the above identified medication to the identified student in accordance with the instructions above for School Year (NOT TO EXCEED CURRENT SCHOOL YEAR) as there exists 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, including emergency situations. Such medication may be administered by medically untrained school personnel.

PLEASE NOTE: *If samples of medication are to be given, they must be labeled with the name of the Student, dosage, and time to be given.*

Healthcare Provider signature: _____Date:_____

Name:_____Telephone: 360-566-9355

Address: Creekside Medical 900 NE 139th street Suite 202 Vancouver, Washington 98685

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

Parent/ Guardian Authorization: (please Initial)

_____ I request that medication be administered to my child/student as described and directed above

_____ I hereby request that the above ordered medication be administered by school personnel and I give permission for the exchange of information between the prescriber and the school nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (3) month supply of medication.

_____ I have administered at least one dose of the medication to my child/student without adverse effects.

I give Creekside Medical permission to fax this form to the school nurse: _____YES _____NO

School Name: _____Fax # to send this form: _____

Parent/Guardian Signature:_____Date:_____

Telephone Home/Cell: _____Work:_____