SNOHOMISH SCHOOL DISTRICT

AUTHORIZATION FOR MEDICATION TO BE TAKEN AT SCHOOL

THE FOLLOWING SECTION IS TO BE COMPLETED BY A PARENT/GUARDIAN:

STUDENT NAME: **LEGAL** LAST NAME	**LEGAL** FIRST NAME	GENDER:	BIRTH DATE:
SCHOOL:	FAX:	GRADE:	TEACHER:
HEALTH CARE PROVIDER'S NAME:	PHONE:	FAX:	

I request that authorized persons help my child take the medicine(s) described below at school or that my child be permitted to medicate themselves/carry medicines as authorized by me and my prescribing health care provider (see below). I give my permission for exchange of information between the school district and the health care provider. I acknowledge that the district shall incur no liability as a result of any injury arising from the district's administration of oral medications in substantial compliance with the prescription.

PARENT/GUARDIAN/STUDENT SIGNATURE:	DATE:
HOME PHONE:	EMERGENCY PHONE:

THE FOLLOWING SECTION IS TO BE COMPLETED BY THE HEALTH CARE PROVIDER:

I HAVE DETERMINED THAT THE MEDICATION NAMED BELOW IS ADVISABLE DURING THE SCHOOL DAY.

DIAGNOSIS:	MEDICATION:	DOSE:	TIME:	ROUTE:	FREQUENCY:	AUTHORIZED TO SELF-ADMINISTER ☐ *YES ☐ NO
SIDE EFFECTS:						
DIAGNOSIS:	MEDICATION:	DOSE:	TIME:	ROUTE:	FREQUENCY:	AUTHORIZED TO SELF-ADMINISTER ☐ *YES ☐ NO
SIDE EFFECTS:						
DIAGNOSIS:	MEDICATION:	DOSE:	TIME:	ROUTE:	FREQUENCY:	AUTHORIZED TO SELF-ADMINISTER ☐ *YES ☐ NO
SIDE EFFECTS:						
DIAGNOSIS:	MEDICATION:	DOSE:	TIME:	ROUTE:	FREQUENCY:	AUTHORIZED TO SELF-ADMINISTER ☐ *YES ☐ NO
SIDE EFFECTS:						

Length of time this medication is needed: ____/____/20____ through ____/____/20____ Entire current school year: 20____________

If I have checked "yes" above, I verify that the student has demonstrated to me the skill level necessary to use the medication and the device necessary to administer the medication.

HEALTH CARE PROVIDER SIGNATURE:	DATE:
HEALTH CARE PROVIDER ADDRESS:	

THE FOLLOWING SECTION IS TO BE COMPLETED BY SCHOOL:

NURSE SIGNATURE:		DATE:
SELF-ADMINISTER ☐ *YES ☐ NO	REVIEWED BY NURSE AND OKAY TO GIVE MEDS:	MEDS ENTERED INTO SKYWARD: **DATE:** **INITIAL:**

This form contains confidential medical information that is not to be shared without permission. **This authorization does not exceed the current school year**