SNOHOMISH SCHOOL DISTRICT

AUTHORIZATION FOR MEDICATION TO BE TAKEN AT SCHOOL

The following section is to be completed by the Parent/Guardian:

Student Name ______________________________ Sex ______ Birth Date ______________

School ______________________ Fax 360-563-________ 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 to be completed by School:

Nurse Signature: ____________________________ ***Self-Administer*** ☐**Yes* ☐ *No* *Date:*_________ *Reviewed by Nurse and okay to give meds* _________

Meds entered in 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