PERMISSION TO ADMINISTER MEDICATION AT SCHOOL

District: **ZILLAH**	School:	Faxes: **Elementary (K-3, & Nurse) 829-6470, Intermediate (4-6) 829-3575, Middle (7-8) 829-0754, High (9-12) 829-5285**

STUDENT: _____ **BIRTH DATE:** _____ **GRADE:** _____

PARENT/GUARDIAN SECTION * *SECCION DE PADRE/GUARDIAN*

I request that the school nurse, or designated staff member, administer the medication prescribed below, in accordance with the healthcare provider instructions. **I give my permission for the following medication information to be shared with school staff on a "need to know" basis.**

Yo pido que la enfermera o personal designado, le administre el medicamento recetada de acuerdo con las instrucciones del medico. ***Doy permiso que la siguiente informacion sea compartida con el personal escolar que necesite estar informado.***

FOR INHALERS AND EPIPENS ONLY (PARA INHALADORS Y EPIPENS SOLAMENTE):

I give permission for my student to carry his/her own emergency medication. ☐yes ☐no
My student is trained to self-administer his/her own emergency medication. ☐yes ☐no

Doy permiso para que mi estudiante pueda traer su medicamento de emergencia. ☐*si* ☐*no*
Mi estudiante tiene conocimiento y entrenamiento de administrarse su propio medicimento. ☐*si* ☐*no de emergencia*

Parent/Guardian Signature *Firma de Padre/Guardian* _____ Date *Fecha* _____ Home phone / Emergency phone *Telefono de Casa* / *Telefono de Emergnecia* _____

HEALTH CARE PROVIDER SECTION

Diagnosis for which medication is to be given during school hours: _____

Name of medication (1 per form): _____ **Dosage:** _____ **Method of administration:** _____ **Time of day to be given:** _____

*If given **prn**, specify length of time between doses (i.e. how soon can it be repeated?):* _____

Other directions for use: _____

Possible side effects: _____ Emergency Action: _____

Duration of Order (must choose one)

☐Medication is ordered for duration of current school year (which may include summer school)
☐Medication to be given from ____/____/____ to ____/____/____.

FOR INHALERS AND EPIPENS ONLY:

May this student carry his/her own emergency medication? ☐yes ☐no
Is this student trained to self-administer his/her own emergency medication? ☐yes* ☐no

****If yes, this student has received instruction in the correct and responsible way to use the medication.***

FOR STUDENTS WITH ASTHMA OR ANAPHYLAXIS: The HCP must submit "A written treatment plan for managing asthma or anaphylaxis episodes of the student and for medication use by the student during school hours" RCW 28A.210.370.

HCP Signature: _____ Date: _____

HCP Printed Name: _____ Phone: _____