AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

NO MEDICATION CAN BE GIVEN AT SCHOOL UNTIL THIS FORM IS COMPLETED AND RETURNED AS IS REQUIRED BY STATE LAW.

Student name _____ Birth date _____

School: _____ Grade _____

Arlington Public Schools is authorized by state statutes RCW28A.210.260 and 28A.210.270 to administer prescribed medication to students during school hours providing that:

1. The medication is accompanied by a written, signed, current, and unexpired request from a licensed health professional prescribing within the scope of his or her prescriptive authority.
2. There exists a valid health reason that makes administration of the medication advisable during school hours.
3. We define medication to mean all drugs, whether prescription or over-the-counter.
4. It is the policy of the District to administer such medication only when absolutely necessary to permit the student to attend school and /or facilitate the student's ability to learn.
5. Requests will be valid only for the medication listed and the dates indicated on this written request form. Medications must be supplied in the original container with label indicating the student's name, name of medication, dosage, expiration date, and instructions for administration. (*Please note if samples of medication are to be given, they must be in the original container, labeled with the name of the student, dosage, route, time to be given, and expiration date.*)
6. Separate medication forms must be completed for each medication to be taken at school.
7. For the protection of all students, an adult is required to deliver and pick up all medication to the school.
8. Requests for the administration of medication are valid for a maximum period of one **school** year, but never past the end of the current school year.
9. Non-licensed/non-medical school personnel trained by a licensed School Nurse may administer only eye drops, ear drops, oral, topical medication.
10. It is the parent/guardian responsibility to report changes in the medication schedule and provide necessary documents and medication to support the requested changes. Forms are available on the District's website under the "For Families" tab.

This portion to be completed by a Licensed Health Care Provider *(MD, ND, DO, PA, ARNP)* **and to accompany medication:**

Name of medication to be taken: _____ Start date: _____

Dose: _____ Route: _____ Time(s): _____ Stop date: _____

Student has been instructed on the proper use and dosage of medication? ☐ Yes ☐ No

Self administered? ☐ Yes ☐ No Student to carry medication at all times? ☐ Yes ☐ No

Reason for medication: _____

Further instructions: _____ Side effects: _____

Allergies: _____

Completed health care plan? ☐ Yes ☐ No

Phone: ___ + ___ - ___ Fax: ___ - ___ - ___ Email: _____

Printed name _____ Signature _____ Date: _____

Parent/Guardian Permission

The medication is to be furnished by me in the original container, labeled by the pharmacy with the name of the student, the name of the medicine, amount to be taken, expiration date, and the time of the day to be taken. The physician's name is on the label. I understand that my signature indicates my understanding that reasonable care will be exercised in the administration of the medication. The school accepts no responsibility for adverse reactions when the medication is dispensed in accordance with the licensed health care provider's direction. If medication remains after the course of treatment, I will collect the medication from the school or understand that it will be destroyed. I understand that failure to supply the necessary documentation and/or medication may result in delay of treatment of my child and possible exclusion until missing items are provided.

Home Phone ___ - ___ - ___ Work Phone ___ - ___ - ___ Cell Phone ___ - ___ - ___

Parent/Guardian Signature _____ Date: _____