Chehalis School District
310 SW 16th St. Chehalis, WA 98532
ph (360) 807-7200 fax (360) 748-8899

AUTHORIZATION FOR ADMINISTRATION OF ORAL MEDICATION AT SCHOOL

Student Name:_____Grade:_____Birthdate:_____

This portion to be completed by the licensed health professional:

Name of Medication	Dosage	Method of Administration	Time of Day To Be Taken

Reason for medication to be given:_____

If given prn, specify the length of time between doses:_____

Inhalers:_____
Indicate if student must carry on his/her person

Possible side effects of medication:_____

What observable side effects do you want us to report:_____

_____

I request and authorize that the above-named student be administered the oral medication identified above in accordance with the instructions indicated above from_____to_____ (not to exceed the current school year), as there exists a valid health reason which makes administration of the medication advisable during school hours.

_____ _____
Licensed Health Professional Date

_____ _____ _____
Print name Phone Fax

This portion to be completed by the parent/guardian:

I request the school to administer medication to the above-named student in accordance with the licensed health professional's instructions for the period from _____to_____(not to exceed the current school year). I understand that every effort will be made by school staff to administer the medication in a timely manner. *The medication is to be furnished by me in the original container, labeled by the pharmacy, with the name of the medicine, the amount to be taken, and the time of day to be taken.* Permission to exchange information is granted until August 31, _____ (end of current school year).

Permission to carry inhaler _____yes _____no

_____ _____/_____ _____
Parent/guardian signature Home phone/work phone Date