RAINIER PREP
AUTHORIZATION FOR MEDICATIONS TO BE TAKEN AT SCHOOL

The following section is to be completed by the PARENT/GUARDIAN: (please print)

School_____ Fax#_____ Grade_____

Student's Name _____ _____ Initial_____

Birth Date_____ ID#_____ Gender_____

_____ _____ _____
(Health Care Provider's Name) (Address) (Phone & Fax)

Please check only one box:

- ☐ I request that authorized persons at school assist my child in taking the medicine(s) described below. I also give my permission for exchange of information between the school district staff and the health care provider.
- ☐ I request that my child be allowed to self-administer medication. I also give my permission for exchange of information between the school district staff and the health care provider. I shall hold harmless and indemnify the school and Rainier Prep's officer, employees and agenda against all claims, judgments, or liability arising out of the self-administration and carrying of medication of my child.
- ☐ I am 18 years or older & am signing this form on my own behalf (RCW 26.28.015 or RCW 70.02.130). I also give my permission for the exchange of information between the school district staff and the health care provider.

_____ _____ _____ _____
(Date) (Parent/Guardian/Student Signature) (Home Phone) (Emergency Phone)

The following section is to be completed by the HEALTH CARE PROVIDER: (please print)

I have determined that the medication named below is advisable during the school day.

Diagnosis for which medication is given: _____

Name of medicine:_____ Dose:_____

Route:_____

If medicine is to be given DAILY, at what time:_____

If medicine is to be given WHEN NEEDED, describe indications: _____

_____

How soon can it be repeated:_____

Is child authorized to medicate herself/himself? (circle) YES NO

If "Yes", student has been trained by health care provider and is safe to self-administer? (circle) YES NO

Length of time this treatment is recommended:_____

Possible side effects: _____

Emergency procedure in case of serious side effects:_____

Date:_____ Health Care Provider's Signature:_____

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Whenever possible we encourage medication doses to be scheduled **during non-school hours**. For those students who need medication during school hours, the following is required by Washington State Law and **must be completed and on file before any medication may be given at school:**

1. **ALL MEDICATIONS (INCLUDING OVER THE COUNTER) TO BE ADMINISTRATED AT SCHOOL REQUIRE AN AUTHORIZED SIGNATURE OF BOTH THE PARENT/GUARDIAN AND A LICENSED HEALTH PROFESSIONAL**

2. **MEDICATION MUST BE IN A PROPERLY LABELED (see list) ORIGINAL PHARMACY CONTAINER**

    - **Student's Name**
    - **Name and Strength of Medication/Including Dosage to be Given**
    - **Time and Method of Administration**
    - **Length of Time/Days to be Given**

3. **MEDICATIONS OTHER THEN ORAL, EYE, EAR, OR TOPICAL MAY NEED TO BE ADMINISTERED BY A LICENSED NURSE: EPINEPHRINE AUTO INJECTORS (Epi-Pen, Auvi-Q) ARE AN EXCEPTION. PLEASE CONTACT YOUR SCHOOL FOR MORE INFORMATION.**

Thank you for your cooperation.

_____ _____

Nurse Signature Date