Authorization for Administration of Medication in Washington State School for the blind

(Includes oral administration, topical medications, eye drops, ear drops or nasal spray)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Student’s Name:  |  |  | School Year:  | 2024-2025 |
| DOB: |  |  | Gr.: |  |  | School: | WSSB 360-947-3388 |  | Fax: 360-737-2120 |  |

**This Portion to be Completed by the Licensed Health Professional (LHP) Prescribing Within the Scope of Their Prescriptive Authority**

|  |  |
| --- | --- |
| Name of Medication: |  |
| Dosage/Frequency: |  |
| Diagnosis or reason for medication:  |  |
| If given PRN, specify the length of time between doses:  |  |
| Possible major side effects of medication:  |  |
| What observable side effects do you want us to report:  |  |
| Student is capable of carrying and administering an inhaler | Yes [ ]  No [ ]   | and/or Epi-pen  | Yes [ ]  No [ ]  |
| I request and authorize that the above-named student be administered the above identified oral medication, topical medication, eye drops, ear drops, nasal spray, or Epi-Pen injection in accordance with the instructions indicated above from ­­­­­­0­7/01/2024 to 8/31/2025, as there exists a valid health reason which makes administration of the medication advisable during school hours, to and from the school and during school sponsored events. |
|  |  |  |  |  |
| Prescribing Licensed Health Professional (Signature required) |  Clinic Name | Date |
|  |  |  |  |  |
| Name (Print or type) |  | Telephone |  | Fax  |

## Provider, please note any over the counter medication student may not have:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Please note:

## 1. Prescribed medication must be provided in the container labeled by the pharmacist with the name of your child, the name of the medication, the dosage and frequency in which the medication is to be given.

2. Over the counter medications must be in the original container.

3. If samples of medication are to be given, they must be labeled with the name of the student, dosage, and time to be given.

4. Medications must be brought to the school by the parent/ guardian

This Portion To Be Completed By The Parent/ Guardian

I request and authorize the school to administer medication to the above identified student in accordance with the health care provider’s instructions. Confidentiality of information provided to my student’s school district is protected by the federal Family Educational Rights and Privacy Act. I may revoke this authorization by writing to my student’s school district. If I did, it would not affect any actions already taken by the school district based upon this authorization.

Once health care information is disclosed, the person or organization who receives it may re-disclose it only in conformance with applicable confidentiality laws.

You have my permission to communicate with this health care provider in order to make arrangements for the care and supervision of my child. I give the health care professional:

Permission to fax this form to the school [ ]  Yes [ ]  No

Permission for my student to carry and self-administer inhaler [ ]  Yes [ ]  No

Permission for my student to carry and self-administer Epi-pen [ ]  Yes [ ]  No

I understand the district shall incur no liability as a result of any injury arising from the self-administration of medication by the student, and parents/guardians shall indemnify and hold harmless the district and its employees or agents against any claim arising out of the self-administration of medication by the student.

Parent/Guardian Signature Date of Signature