Lynden School District No. 504

AUTHORIZATION FOR ADMINISTRATION OF ORAL MEDICATIONS AT SCHOOL

Student:	Birthdate:
School:	Teacher

THIS PORTION TO BE COMPLETED BY STUDENTS' PHYSICIAN OR DENTIST

Medication will be given to a student at school only when absolutely necessary. The parent and legal prescriber are urged to design a schedule for giving medication outside of school hours. If this is not possible, it must be understood that the medication will be given by the designated school personnel employed by the District. Only oral medication will be administered.

The school accepts no responsibility for adverse reactions when the medication is dispensed in accordance with the directions of the student's physician or dentist. Orders must be non-discretionary and legible.

Name of Medication:____________________

Inhalers:____________________

Indicate if student must carry on his/her person: YES _______ NO _______

Dosage:____________________

Time(s) of Dosage:____________________

Anticipated Action of Medication:____________________

Length of Prescription Period: From ____________________ To ____________________

Possible Side Effects:____________________

Emergency measures in case of serious side effects:____________________

I certify that valid health reasons exist requiring that medication be administered during school hours or during such time that the student is under supervision of school officials.

I request and authorize that the above-named student be administered the above-named medication in accordance with the instructions indicated. If Diabetic, please attach orders.

____________________ ____________________

Date of Signature Physician/Dentist Signature

(Physician's Assistant's orders must be countersigned by supervising MD)

____________________ ____________________

Telephone Number Name (Print or Type)

THIS PORTION OF FORM IS TO BE COMPLETED BY THE PARENT/GUARDIAN

I certify that I am the parent, legal guardian, or other person in legal control of the identified student above. I have read this form, the Lynden School District Board Policy 3416 & 3416P and request/authorize the school to administer the medication prescribed.

I understand that the medication must be furnished in an original container from the pharmacy with the student's name, the name of medication, and the amount to be given. Non-prescription medication must be furnished in the original container from the manufacturer. All medication must be in a form ready to be administered and must not require any preparation by building staff.

I understand that it is the parent's responsibility to deliver and maintain an adequate supply (not more than one month supply) of the medication at school. **The child or school bus driver may NOT deliver the medicine. Medication delivered by child or bus driver will NOT be dispensed**.

I understand that my signature indicates that the school accepts no liability for adverse reactions when the medication is administered in accordance with the physician's directions. I also understand that because of the school's schedule and the other responsibilities of school staff members, there may be occasions in which a dosage may be delayed or missed. If there is any medication left at the end of the school year, it will be destroyed if I do not pick it up within 5 working days after school is out.

I understand that as a general rule, the district will not administer prescribed oral medication during field trips. I understand that in those instances where medication must be administered, I am to make arrangements at least 24 hours prior to the field trip.

____________________ ____________________

Parent/Guardian Signature Date

____________________/____________________

Home Telephone Number Work Telephone Number