LYNDEN SCHOOL DISTRICT
Tradition + Pride + Excellence

MEDICATION AUTHORIZATION FORM - Lynden School District No. 504 **School Year:** _____

For ALL prescription or over the counter medications administered at school

School: _____ **Fax:** 360-354-_____

This section must be completed by the PARENT / GUARDIAN: (please print)

Student: _____ DOB: _____ Grade: _____

Medication(s) requested: _____

Health Care Provider: _____ Phone & Fax: _____

Please check only one box & sign below:

□ I request that the authorized persons at **school assist my student** in taking the medicine(s) described below.

□ I request that my child be allowed to **self-carry and/or self-administer this medication**. My student and I understand the responsibility of self-carrying medication at school and recognizes the school will not track compliance, expiration, or amount. I agree to hold harmless and indemnify the school and Lynden School District's officers, employees, and agents against all claims, judgments, or liabilities arising out of the self-administration and carrying of medication by my student.

I understand that:

- I will keep track of expiration dates for the medication(s)
- My signature gives permission for exchange of information between the School Nurse and the Health Care Provider regarding this medication order.
- I will furnish medication(s) in original container and pick up medication(s) from the school

_____ Date: _____ Phone: _____

Parent / Guardian / Student signature

This section to be completed by the HEALTH CARE PROVIDER (please print): (MD, DO, ND, DMD, DC, PA, ARNP or CNM)

	Medication #1	Medication #2
MEDICATION name:		
DOSE:		
ROUTE:		
Reason/Diagnosis (if epinephrine, please state specific allergens):		
Time of dose:		
Side effects:		
When to repeat?		
Is student capable of self-carry & safe administration? *	□ Yes - student may self-carry and self-administer □ No - student may not self-carry □ No – student may not self-administer	□ Yes - Student may self-carry and self-administer □ No - student may not self-carry □ No – student may not self-administer
***Checking "Yes"** indicates that student has been thoroughly instructed in the purpose and appropriate method/frequency of use and/or safe carrying of medication. Student/parent/guardian understand the responsibilities of self-carrying at school.		
Authorization for:	□ School year □ Other dates:	□ School year □ Other dates:
I request that the above named student be administered the above medication in accordance with the instructions indicated, as there exists a valid health reason which makes administration advisable during school hours.		

Licensed Health Care Provider's Signature:	**Date:**	Phone:
		Fax:

MEDICATION AUTHORIZATION FORM – Lynden School District No. 504

In most cases where a student needs medication (prescription or non-prescription) it should be given before and/or after school hours at home. If there is a valid health reason which requires school staff to administer medication to a student during school hours, or during the hours in which the student is under the supervision of school officials, the following procedures shall apply consistent with RCW 28A.210.320, RCW 28A.210.260 and the Washington State Nurse Practice Act.

A prior written request and authorization (over) from the parent/guardian **and medication orders from** the prescribing licensed Health Care Provider must be on file for the following categories of medication:

1. Any over-the-counter non-prescription medication (except sun-screen)
2. All prescription medication

Written authorization will be effective for the current school year unless a shorter time period is specified by the licensed Health Care Provider.

Parent/Guardian responsibilities:

- ☐ Complete the top section of medication authorization form (fill in every line).
- ☐ Have Health Care Provider fill out bottom section of medication authorization form.
- ☐ With the Health Care Provider, determine if student can carry and/or administer their own medication. If yes – indicate so in *both* parent and Health Care Provider sections
- ☐ Ensure form is *completed* before returning form to school
- ☐ Medication must be provided in a properly labeled container
- ☐ Adults must deliver and pick up medication to/from school. If there are extenuating circumstances, please consult school nurse and principal.
- ☐ Track the expiration date for medications at school and resupply as needed
- ☐ If you take medication home for safe-keeping over breaks, be aware that for students with Individual Health Plans, medication **must be returned** to school promptly on the first day after break.
- ☐ **Parents/Guardians please note:** Your child's health information, IHP and medication is for use during the school day and on school-sponsored field trips only. Extended day, childcare, clubs, before & after school, evening, and summer activities **do not have** access to this Individual Health Plans or medication kept in the Health Room. Please contact these activities/programs directly.

Prescription medication must be in original pharmacy container labeled with:

- Student name
- Medication name
- Strength of medication
- Dose
- Time of administration

Non-prescription medication should be provided in the original container with:

- Student name

School responsibilities:

- Persons who administer medication include School Nurses and any employee trained and supervised by a School Nurse in proper procedures for administration of medication
- The administration of medication will be recorded on an individual medication log
- Medications provided by parent/guardian will be tracked/checked in and out
- School will keep medications in a secure location in the Health Room

Legal references:
RCW 28A.210.320 Children with life-threatening health conditions — Medication or treatment orders
RCW 28A.210.260 Public and private schools — Administration of medication — Conditions
RCW 28A.210.270 Public and private schools — Administration of medication — Immunity from liability — Discontinuance, procedure