Wilson Creek Medication Authorization

For Oral, Topical, Eye, or Ear Drop Medication Administration at School

Student Name: _____ Birth Date: _____

School: ___Wilson Creek School District_____ Grade: _____

LICENSED HEALTH PROFESSIONAL (LHP)

Complete this section using one form for each medication

Diagnosis or reason for medication: _____

Severity of the problem: ❑ mild ❑ moderate ❑ severe

Activity modifications or restrictions: _____

Name of Medication	Dosage	Method of administration	Time to be given or frequency if PRN

If given PRN, describe indications: _____

Can the student travel on field trips > 30 minutes away from emergency medical response? ❑ Yes ❑No

Possible side effects of medication:_____

Student is capable of **self-administration** of medication and has received instruction in the correct and responsible way to use the medication: ❑ Yes ❑ No

Student can carry the medication on their person responsibly: ❑ Yes ❑ No

I request and authorize that the above-named student be administered or self-administer this oral medication according to the instructions indicated above from ___/___/___ to ___/___/___ ❑ End of current school year (not to exceed current school year) as there exists a valid health reason which makes administration of the medication advisable during school hours.

_____ _____

Date of Signature *Licensed Health Professional*

_____/_____ _____

Phone *FAX* *Name (Print)*

PARENT or GUARDIAN

To complete this section

I request and authorize the school to administer medication to the above student in accordance with the LHP's instructions for the period from ___/___/___ to ___/___/___ or ❑ End of current school year (not to exceed the current school year). I understand that information about this medication and health problem will be shared with school staff that need to know.

I give my permission for my child to carry this medication with them at school: ❑ Yes ❑ No

I give my permission for my child to self-administer medication: ❑ Yes ❑ No

*Self-administration of meds must be approved by the school nurse and student must sign a contract of use.

If I give permission for self-administration or for my child to carry medication, I understand and agree that the district shall incur no liability as a result of any injury arising from the self-administration of medication by the student and I hold harmless the district and its employees or agents against any claims arising out of the self-administration of medication by the student.

_____ _____

Date of Signature *Parent/Guardian Signature*

_____ _____

Home Phone *Work or Cell Phone*

 Reviewed by RN/LPN: _____ on ____/___/___