EASTSIDE CATHOLIC

2021-22 Authorization for Administration of Medication for High School Students

Student Name: _____ Birthdate: _____ Grade: _____

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

MD Prescription Authorization on next page

I give my permission for the exchange of information between Eastside Catholic School and the licensed healthcare provider listed on page 2.

Parent/Guardian signature: _____ Date: _____

Name of medication: _____ Dosage: _____ Time to be given: _____

Diagnosis or reason for medication/other medication the student is taking: _____

_____

Student may carry and self-administer medication: YES _____ NO _____

For student self-administration: I certify that I am the parent/legal guardian of the above-named student. I authorize my student to carry and self-administer one day's dose of medication as specified. I shall hold harmless and indemnify Eastside Catholic School officers, employees and agents against all claims, judgments or liabilities arising out of the self-administration of medication as described.

For staff administration: I request/authorize the school to administer the above medication to the above identified student in accordance with the licensed health care provider's instructions for the period from _____ to _____, not to exceed the current school year.

Parent/guardian signature _____ Date _____

Home phone _____ Cell phone _____ Work phone _____

Health Room approval _____ Date _____

Medication Policy for High School Students

An **Authorization for Administration of Medication for High School Students** MUST be filled out and on file before any medication can be given. Please carefully READ the following criteria for all medications students may take or carry to school. Whenever possible, we encourage medication doses to be scheduled during non-school hours.

For those students who need medication at school, the following is required by Washington State Law:

OVER-THE-COUNTER MEDICATIONS/PRODUCTS

- An **Authorization for Administration of Medication to High School Students** form must be completed by a parent or guardian consenting that their high school student may self-administer one day's dose of over-the-counter medications while at school.
- If the parent/guardian prefers for school staff or Health Room volunteers to administer medication, a licensed health care provider with prescriptive authority must also complete instructions.
- Medication must be in its original container. All medications must be provided by the parents.

SHORT-TERM PRESCRIBED MEDICATION (15 school days or less)

- An **Authorization for Administration of Medication for High School Students** form must be completed by both parent/guardian and a licensed health care provider with prescriptive authority (see back of form).
- Medication must be in a properly labeled container. You may ask for a duplicate container at the dispensing pharmacy.
- Parents and guardians or students must deliver the prescribed medication to the Health Room.

LONG-TERM PRESCRIBED MEDICATION (16 school days or more)

- An **Authorization for Administration of Medication for High School Students** form must be completed by both parent/guardian and a licensed health care provider with prescriptive authority.
- Medication must be in a properly labeled container. You may ask for a duplicate container at the dispensing pharmacy.
- Parents and guardians or students must deliver prescribed medication to the health room for storage or review by school nurse before the start of classes. If the student prefers to carry their own medication, it must be reviewed by the school nurse and only one day's dose may be carried in the original bottle on any given day. Emergency medication must be carried or available at all times while participating in school activities.
- **Additional detailed instructions and a care plan are required from your licensed health care provider.**

Please Note: Only oral medications can be given by a non-nurse school staff. EpiPens are the only exceptions.

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THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTHCARE PROVIDER

Patient name: _____

Diagnosis for which medication is given: _____

Name of medicine: _____ Dosage: _____

Route: _____ Time to be given: _____

If medicine is to be given **as needed**, please describe indications: _____

_____

If medicine is prescribed for a limited length of time, please write duration: _____

_____

List significant side effects: _____

_____

Other information: _____

For inhalers: Student is capable of carrying and self-administration: YES* ☐ NO ☐

For EpiPen/EpiPen Jr.: Student is capable of carrying and self-administration: YES* ☐ NO ☐

*Checking YES indicates that the student has been instructed in the purpose and appropriate method/frequency of use.

I request and authorize the school to administer or allow self-administration of the above medication to the above-named student in accordance with the instructions indicated above for the period from _____ to _____, not to exceed the current school year.

Healthcare provider's signature: _____ Date: _____

Healthcare provider's printed name: _____

Phone number: _____ Fax number: _____

HEALTHCARE PROVIDERS PLEASE NOTE: For all patients requiring LONG-TERM PRESCRIPTIONS (i.e., diabetics, asthmatics, severe allergies), a written prescription and a long-term care plan are required to provide the best care possible to the student during the school year. See Medication Policy for High School Students on the reverse side.