EASTSIDE CATHOLIC

2021-22 Authorization for Administration of Medication for *Middle School* Students

Student Name: _____ **Birth date:** _____ **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 health care provider listed on page 2 of this form.

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

Diagnosis or reason for medication: _____

_____

Other medication the student is taking: _____

I request and authorize the school to administer the identified medication to the above student in accordance with the health care provider's prescribed instructions, not to exceed the current school year. I give my permission for exchange of information between the school and the licensed health care provider. I understand that the medication is to be furnished by me in the original container. For self-administration of inhaler or EpiPen, I authorize my child to carry and self-administer such medication, if authorized by a licensed practitioner. I shall hold harmless and indemnify Eastside Catholic School's officers, employees and agents against all claims, judgments or liabilities arising out of the self-administration of medication as described.

Parent/guardian signature: _____ Date: _____

Home phone: _____ Cell phone: _____ Work Phone: _____

Health Room approval: _____ Date: _____

MEDICATION POLICY FOR MIDDLE SCHOOL STUDENTS

An ***Authorization for Administration of Medication to Middle 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 for Middle School Students** form must be completed by both parent/guardian **and** a licensed health care provider with prescriptive authority.
- Over-the-counter medication **must** be in its original container with expiration dates checked by parent.
- All over-the-counter student medications must be provided and delivered to the Health Room by a parent/guardian.
- All medications will be distributed by the nurse. No middle school students are permitted to carry own medication.

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

- An **Authorization for Administration of Medications for Middle School Students** form must be completed by both parent/guardian **and** a licensed health care provider with prescriptive authority.
- Prescribed medication must be in a properly labeled container. You may ask for a duplicate container at the dispensing pharmacy.
- Parents must deliver the prescription medications to the Health Room.

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

- An **Authorization for Administration of Medication for Middle School Students** form must be completed by both parent/guardian **and** a licensed health care provider with prescriptive authority.
- Prescribed medication must be in a properly labeled container. You may ask for a duplicate container at dispensing pharmacy.
- Parents must deliver long-term prescription medication to the school.
- **Additional detailed instructions, a care plan, are required from your licensed health care provider.**

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

EASTSIDE CATHOLIC

2021-22 Authorization for Administration of Medication for *Middle School* Students

THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH CARE 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 that the above-named student be administered the above identified medication in accordance with the instructions indicated. Medication orders are good for the current school year, unless a shorter period is specified or unless there exists a valid health reason which makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials.

Health care provider's signature: _____Date: _____

Health care provider's printed name: _____

Phone number: _____ Fax number: _____

School nurse approval: _____ Date: _____

Health care 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 Middle School Students on the reverse side.