**Conway School District**

**19710 State Route 534, Mount Vernon, WA 98274**

School Fax 360-445-4511 (if authorization is faxed, original must be mailed to the school)

**AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH CARE PROVIDER completes this section: (please print)**

**Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_\_ Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_**

**Scheduled Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Scheduled Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

□Epi-pen □Tablet/Capsule □Liquid □Injection □Inhaler □Epi-pen □Tablet/Capsule □Liquid □Injection □Inhaler

□Eye Drops □Ear Drops □Topical □Other\_\_\_\_\_\_\_\_\_\_\_ □Eye Drops □Ear Drops □Topical □Other\_\_\_\_\_\_\_\_\_\_\_

**□Student May Carry and Self Administer Inhaler □Student May Carry and Self Administer Inhaler**

If medicine is to be given AS NEEDED, describe indications: If medicine is to be given AS NEEDED, describe indications:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How soon can it be repeated? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How soon can it be repeated? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Storage Instruction:□Room Temperature □Refrigeration Storage Instruction:□Room Temperature □Refrigeration

Diagnosis/reason for medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diagnosis/reason for medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Length of time this treatment is recommended: \_\_\_\_\_\_\_\_\_\_ Length of time this treatment is recommended: \_\_\_\_\_\_\_\_\_\_

□Current School Year (including summer) □Current School Year (including summer)

Significant side effects: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Significant side effects: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Care Provider Signature:**  **Health Care Provider Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARENT/GUARDIAN completes this section:**

 I request that my child be allowed to take the medication as described above/Doy permiso de que *mi hijo(a) tome este medicamento*. I will provide the medication in the original, properly labeled container/*El medicamento esta en su contenido original.* I understand that if I do not pick up any medication left at the end of the school year, it will be destroyed/*Yo entiendo que si no recojo el medicamento al final de ano escolar, se van tirar*. I give my permission for school staff to communicate freely with this health care provider/*Yo doy permiso de que el personal de la escuela pueda comunicarse con el doctor*. I understand that my signature indicates my understanding that the school staff shall not incur any liability for any injury when the medication is administered in accordance with the health care provider’s direction and in accordance with the District Policy and Procedure 3416, 3419 and 3420/*Yo entiendo que mi firma indica que la escuela no tiene ninguna responsabilidad por algún daño ocurrido, cuando la* medicina se da como indicado por el doctor. Esta es la póliza del Distrito y procederé 3416 y 3419 y 3420.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date/*Fecha***  **Parent/Guardian Signature/*Firma del Padre/Guardián*** 5/21