School Health Consultants
Port Townsend School District
1610 Blaine Street
Grant Street Fax : 379-4261
Blue Heron Fax : 302-2505
PTHS Fax : 379-4506

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

For 2018-2019 School Year

**** THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH PROFESSIONAL (LHP) ****

Name of Student: _____Date of Birth: _____

Reason for Medication: _____

Name of Medication: (*one per form)*_____

Dosage & Mode of Administration: _____

If given for allergic reason, describe indicators: _____

Time to be given: _____

Inclusive dates during which medication is to be given: _____

Possible side effects of medication: _____

***Self carry/administer of medication: (for epi pen, inhaler ONLY): Students may not self carry or administer these medications unless this line is initialed by the LHP. The Licensed Healthcare Provider verifies this student has been taught proper administration of the above medication and can use it properly without supervision.) _____**
(RCW 28A.210.370A) Initial here

Licensed Health Professional: _____ Phone: _____
(Please Print)

Signature Date

**** THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN ****

I request/authorize the school to administer medication to the above identified student in accordance with the LHP's instructions for a period from _____ to _____ (*not to exceed current school year*). I understand that every effort will be made by school staff to administer the medication in a timely manner, but it is possible for a dose to be delayed or missed. I will deliver the prescribed medication to the school in the original pharmacy container with the label intact**. *(Student may not hand carry medication to school unless it is an Epi-Pen or Inhaler and the line above is initialed by the LHP. Parent grants permission for student to possess and use an inhaler or epi pen(1) at school, (2)at school sponsored activities and(3) before/after school while on school property.**

I agree to hold Port Townsend School District harmless for any liabilities it may incur in connection with this requested medication at school when medication is administered in accord with LHP's written direction.

School Student Attending: _____

Parent/Guardian Name: _____
(Please Print)

Phone: Home _____ Work _____ Cell _____

Parent/Guardian Signature _____ Date _____