NORTHWEST CHRISTIAN SCHOOLS OF LACEY

Authorization for Administration of Medication at School

Student Name: _____ DOB: _____

School Year: _____ Grade: _____

THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH PROFESSIONAL (LHP) PRESCRIBING WITHIN THE SCOPE OF THEIR PERSCRIPTIVE AUTHORITY.

Name of Medication	Dose	Methods of Administration	Time of Day to be Taken

Diagnosis or reason for medication: _____

If given PRN, specify the length of time between doses: _____

Possible side effects of medication: _____

Emergency procedure in case of side effects: _____

Inhalers – Student is capable of self-administration of medication. ☐ Yes ☐ No

Permission to carry inhaler. ☐ Yes ☐ No

I REQUEST AND AUTHORIZE THE ABOVE NAMED STUDENT TO BE ADMINISTERED THE ABOVE IDENTIFIED MEDICATION IN ACCORDANCE WITH THE INSTRUCTIONS INDICATED ABOVE FROM _____ TO _____ (NOT TO EXCEED THE CURRENT SCHOOL YEAR) AS THERE EXISTS A VALID HEALTH REASON WHICH MAKES ADMINISTRATION OF THE MEDICATION ADVISABLE DURING SCHOOL HOURS.

Signature of LHC Professional: _____

Printed Name: _____

Phone Number: _____ Date: _____

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I authorize the school to administer medication to the above identified student in accordance with LHP's instructions.

Parent/Guardian Signature: _____

Best Contact Number: _____ Date: _____

VALID FOR CURRENT SCHOOL YEAR ONLY

Please return completed form to the school office.

Fax (360) 412-0910