King's Way Christian Schools
Student Health Services

AUTHORIZATION FOR ADMINISTRATION OF NON-PRESCRIPTION MEDICATION AT SCHOOL

Student Name:			Birth Date:	Allergies:
Elementary	M.S.	H.S.	Grade:	Teacher:

I give the School Nurse of King's Way Christian Schools permission to administer the following medications at her discretion for the temporary relief of discomfort associated with a cold, fever, headache, dental discomfort, muscular aches, pre-menstrual or menstrual pain, sore throat, upset stomach, allergic reactions, rashes due to Poison Ivy, Oak or Sumac, coughs, cuts and scrapes.

(Please check any medication you wish to be made available to your child)

_____Acetaminophen (like Tylenol)	10-15mg/kg per dose every 4 hours as needed
_____Ibuprofen (like Advil)	10mg/kg per dose ever 4 – 6 hours as needed
_____Diphenhydramine HCL (like Benadryl)	Ages 6-12: 12.5 – 25mg every 4 – 6 hours as needed
or other Antihistamine	Age over 12: 25 – 50 mg every 4 – 6 hours as needed
_____Ointment (like Bacitracin, Neomycin)	Small amount to cuts and scrapes as needed
_____Anti-itching lotion (like Calamine)	Apply to affected area every 4 hours as needed
_____Chewable antacid tablets (like Tums)	1-2 tablets every 4 hours as needed
_____Cough drops (like Halls, Ludens or hard candy)	As needed for coughing

- I hereby give my permission for the above-named student to receive any medication listed above as deemed necessary by the school nurse. I have checked those medications I wish to be made available to my child.
- I request that authorized school staff assist my child in taking the oral medication(s) described above.
- I understand that school staff will attempt to administer medication in a timely manner.
- I understand that only a registered nurse may apply any ointment to my child's cuts, scrapes, and rashes.
- I will provide the oral medication in the original, properly labeled container.
- I give my permission for the exchange of information between the school staff and health care provider.
- I understand that only these medications and doses listed will be administered. If my child needs additional medication or a different dose my child will need a separate order (On the Authorization for Administration of Oral Medication at School form) signed by a health care provider.
- I understand 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 school policy and Washington State Law (RCW 28A.210.260).

****THIS PORTION MUST BE COMPLETED BY THE HEALTH CARE PROVIDER****

I authorize that the above-named student be administered the above identified medication(s) in accordance with his/her parent/guardian's request, and according to instructions indicated above from _____ to _____ (not to exceed the current school year).

_____ _____
Health Care Provider Signature Date

_____ _____
Print Name Phone Number

_____ _____
Parent/Guardian signature Date

Home phone number_____ Cell/work phone_____

Form may be returned to King's Way via fax if needed (360) 573-5895 (ATTN: Nurse)