King's Way Christian Schools
Student Health Services

AUTHORIZATION FOR ADMINISTRATION OF ORAL MEDICATION AT SCHOOL

Student Name: ________________________________ Birth Date:________ Allergies:______________

School: ____ Elementary ____ Middle School ____ High School Grade: ____ Teacher:______________

THIS PORTION IS TO BE COMPLETED BY THE PHYSICIAN/DENTIST

Name of Medication	Dosage	Method of Administration	Time of Day to Be Taken
____________________	______	____________________	____________________
____________________	______	____________________	____________________
____________________	______	____________________	____________________

Diagnosis or reason for medication: ____

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

Is student allowed to carry and self-administer "rescue inhaler"? _____Yes _____ No
If **yes,** this student is trained in the purpose and appropriate method and frequency of use.

Student is capable to self-administer medication? _______ Yes _______ No

Possible side effects of medication (s): ____

Emergency procedure in case of serious side effects: ____________________________________

I request and authorize that the above-named student be administered the above identified oral medication(s) 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.

______________________________ ______________________________
Physician/Dentist Signature Date

______________________________ ______________________________
Print Name Phone Number

Please note: If sample of medication are to be given, they must be labeled with the name of the student, dosage, and time to be given.

THIS PORTION IS TO BE COMPLETED BY THE PARENT/GUARDIAN

- I request that my child be allowed to take the medication as described above.
- I request that authorized school staff assist my child in taking the medication(s) described above.
- I understand that school staff will attempt to administer medication in a timely manner.
- I will provide the 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 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 doctor's/dentist's direction and in accordance with school policy and Washington State Law (RCW 28A.210.260).

______________________________ ______________________________
Parent/Guardian signature Date

Home phone number______________________ Cell/work phone______________________

*PRN is Latin for "pro re nata," (as the situation demands). Medication is to be given as needed.

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