AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN VANCOUVER SCHOOL DISTRICT

(Includes oral administration, topical medications, eye drops, or ear drops)

Student's Name: _____ School Year: 2019-2020

DOB: _____ Gr.: _____ School: VSAA School Fax: 360-313-4601

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

Name of Medication: _____

Dosage/Frequency: _____

Diagnosis or reason for medication: _____

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

Possible major side effects of medication: _____

What observable side effects do you want us to report: _____

Student is capable of carrying/administering inhaler Yes ☐ No ☐ and/or Epi-pen Yes ☐ No ☐

I request and authorize that the above-named student be administered the above identified oral medication, topical medication, eye drops, ear drops, or Epi-Pen injection in accordance with the instructions indicated above from 8/2019 to 8/2020 (not to exceed current school year), as there exists a valid health reason which makes administration of the medication advisable during school hours.

Prescribing Licensed Health Professional (Signature required)	Clinic Name	Date
Name (Print or type)	Telephone	Fax

Please note:

1. Prescribed medication must be provided in the container labeled by the pharmacist with the name of your child, the name of the medication, the dosage and frequency in which the medication is to be given.
2. Over the counter medications must be in the original container.
3. If samples of medication are to be given, they must be labeled with the name of the student, dosage, and time to be given.
4. Medications must be brought to the school by the parent/ guardian.

THIS PORTION TO BE COMPLETED BY THE PARENT/ GUARDIAN

I request and authorize the school to administer medication to the above identified student in accordance with the health care provider's instructions. Confidentiality of information provided to my student's school district is protected by the federal Family Educational Rights and Privacy Act. I may revoke this authorization by writing to my student's school district. If I did, it would not affect any actions already taken by the school district based upon this authorization.

Once health care information is disclosed, the person or organization who receives it may re-disclose it only in conformance with applicable confidentiality laws.

You have my permission to communicate with this health care provider in order to make arrangements for the care and supervision of my child. I give the health care professional:

Permission to fax this form to the school	☐ Yes	☐ No
Permission for my student to carry and self-administer inhaler	☐ Yes	☐ No
Permission for my student to carry and self-administer Epi-pen	☐ Yes	☐ No

I understand the district shall incur no liability as a result of any injury arising from the self-administration of medication by the student, and parents/guardians shall indemnify and hold harmless the district and its employees or agents against any claim arising out of the self-administration of medication by the student.

Parent/Guardian Signature	Date of Signature