

**AUTHORIZATION FOR ADMINISTRATION OF ORAL MEDICATION AT SCHOOL**

CEDAR PARK CHRISTIAN SCHOOLS  
16300 112th Ave. NE  
Bothell, WA 98011-1535  
488-9778

Student's name \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_ Birthdate \_\_\_\_\_

<u>NAME OF MEDICATION</u>	<u>DOSAGE</u>	<u>METHOD OF ADMINISTRATION</u> (i.e., tablets or liquid)	<u>TIME OF DAY TO BE TAKEN</u>
_____	_____	_____	_____

DATES TO BE ADMINISTERED: beginning on \_\_\_\_\_, 20\_\_\_\_, through \_\_\_\_\_, 20\_\_\_\_.

Reason for medication to be given during school hours:

\_\_\_\_\_  
\_\_\_\_\_

Anticipated action: \_\_\_\_\_

Possible side effects of medication:

\_\_\_\_\_

Emergency procedure in case of serious side effects:

\_\_\_\_\_

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student and request and authorize the school to administer the above identified medication in accordance with the instructions indicated above for the period of time described above, as there exists a valid health reason which makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials. Such medication may be administered by medically untrained school personnel.

Medication will be supplied to the school in the original container.

\_\_\_\_\_  
Parent signature

\_\_\_\_\_  
Parent name (print)

\_\_\_\_\_  
Date of signature

\_\_\_\_\_  
Telephone number – home

\_\_\_\_\_  
Telephone number - work

\_\_\_\_\_  
Physician signature

\_\_\_\_\_  
Physician's telephone number

Record of administration (list date, time, dosage, and name of school personnel administering medication):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_