Cedar Park
CHRISTIAN SCHOOLS

MEDICATION AUTHORIZATION

Please print…

STUDENT NAME:_____ **BIRTHDATE:** _____ **GRADE:** _____ **TEACHER:** (elem.) _____

PARENT/GUARDIAN: _____ **PHONE:** _____ **ALT. PHONE:** _____

- Cedar Park Christian School's policy regarding dispensation of medication is pursuant to Washington State law (RCW 28A.210.260 and 270), "***For the administration of any medication, prescription or over the counter, the school is required to obtain a written, current, and unexpired request from a licensed health professional ("LHP") prescribing within the scope of the professional's prescriptive authority***."
- School employees are authorized to administer prescribed medication to students only when the student requires such medication in order to attend school, or if the student is susceptible to a predetermined life-threatening condition.
- Medications must be delivered to the school by the parent/guardian, in the original prescription bottle, properly labeled with the student's name, identification of the medication, dosage and directions for administration. Parents/guardians are responsible to notify the school and provide written verification of any changes in the medication or instructions for administration. If needed for field trips, please request an extra labeled empty bottle from your pharmacist.
- Over the counter medications must be delivered in the original container.
- A separate form must be submitted for each medication. Authorization is only valid during the current school year.
- All medications must be picked up by the last day of school, or will be disposed of.
- Student Self-Administered Medication: Authorization may be applicable for a student to self-administer certain medications (i.e., asthma inhalers, EPI-pens, etc.), with instructions and approval of the Licensed Health Professional and the parent/guardian (see below).

1. This section to be completed by the Licensed Health Professional for all prescribed or over-the-counter meds:

Please print…

NAME:_____ **PHONE:** _____ **EMAIL:** _____

Diagnosis or reason for medication: _____

Name of medication: _____ Dosage: _____

Time/frequency: _____ *If medication is to be given AS NEEDED, describe instructions: _____

_____

Possible side effects: _____

Start Date: _____ End Date : _____ (no later than the end of the current school year)

Is child authorized to carry and self-administer? ***Circle one: YES NO * If yes, I have trained this student in the proper administration and frequency of use.***

Signature: _____ **DATE:** _____

2. Parent/Guardian:

I certify that I am the parent or legal guardian of this student and request and authorize the school to administer medication in accordance with the instructions indicated above, as there exists a valid health reason which makes administration of the medication advisable during school hours. Such medication may be administered by medically untrained school personnel. I consent to the exchange of information between the school and the Licensed Health Professional regarding this authorization. I understand that the school shall incur no liability as a result of any injury arising from the administration or self-administration of medication, and shall hold harmless the school and its employees or agents against any claim arising thereof.

Signature: _____ Date: _____