2200 Williams Blvd. Richland, WA 99354 - 509-946-0602 Fax: 509-943-5623

Authorization for Administration of Medication at School

Student Name: _____ Birthdate: _____ Grade: _____

This Portion to be completed by a licensed health professional (LHP) prescribing within the scope of their prescriptive authority.

(Please clearly print legible instructions)

Name of Medication	Dosage	Method of Administration	Time(s) to Be Taken	Reason and Special instructions for Medication
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

I request and authorize this student to carry their inhaler/epi-pen. **(secondary only)** Yes No

I request and authorize this student to self-administer their inhaler/epi-pen. **(secondary only)** Yes No

Possible Medication side effects: _____

_____

Emergency Procedure in case of serious side effects: _____

I request and authorize the above-named student be administered the above identified medication in accordance with the instructions indicated above from _____ (date) to _____(date) (**not to exceed current school year**). There exists a valid health reason which may make administration of the medication advisable during school hours.

REQUIRED Signature of Licensed Health Professional (LHP) Date

Name (please print) Phone

This portion to be completed by a parent or guardian

I request this medication to be given as ordered by the **licensed health professional**.
I give Liberty Christian School Staff permission to communicate with the medical office about the medication.
I understand oral medications may be administered by non-lincensed staff members.
Medication information may be shared with school staff working with my child and 911 staff, if they are called.
All medication supplied must be brought to school the orignal container with instructions as noted above by the licensed health professional.

Parent Signature: _____ Date: _____

Rev. 5/16/17