Seattle Public Schools
AUTHORIZATION FOR MEDICATIONS TO BE TAKEN AT SCHOOL

The following section is to be completed by the PARENT/GUARDIAN: (please print)

School GARFIELD HIGH SCHOOL Fax# 206 743 3121 Grade________

Student's Name ________________________________ __________________________ Initial________

Birth Date________________________ ID#______________________ Gender_____________________

________________________________ (Health Care Provider's Name) ________________________ (Address) __________________________ (Phone & Fax)

Please check only one box:

- ☐ I request that authorized persons at school assist my child in taking the medicine(s) described below. I also give my permission for exchange of information between the school district staff and the health care provider.
- ☐ I request that my child be allowed to self-administer medication. I also give my permission for exchange of information between the school district staff and the health care provider. I shall hold harmless and indemnify the school and Seattle Public School District's officer, employees and agenda against all claims, judgments, or liability arising out of the self-administration and carrying of medication of my child.
- ☐ I am 18yo or older & am signing this form on my own behalf (RCW 26.28.015 or RCW 70.02.130). I also give my permission for the exchange of information between the school district staff and the health care provider.

_______________ (Date) ___________________________________ (Parent/Guardian/Student Signature) __________________ (Home Phone) __________________ (Emergency Phone)

The following section is to be completed by the HEALTH CARE PROVIDER: (please print)

I have determined that the medication named below is advisable during the school day.

Diagnosis for which medication is given: ____

Name of medicine:__________________________________ Dose:___________________________

Route:____

If medicine is to be given DAILY, at what time:____

If medicine is to be given WHEN NEEDED, describe indications: ____________________________

____

How soon can it be repeated:____

Is child authorized to medicate herself/himself? (circle) YES NO

If "Yes", student has been trained by health care provider and is safe to self-administer? (circle) YES NO

Length of time this treatment is recommended:____

Possible side effects: ____

Emergency procedure in case of serious side effects:____________________________________

Date:_________________ Health Care Provider's Signature:_________________________________

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Whenever possible we encourage medication doses to be scheduled **during non-school hours**. For those students who need medication during school hours, the following is required by Washington State Law and **must be completed and on file before any medication may be given at school:**

1. **ALL MEDICATIONS (INCLUDING OVER THE COUNTER) TO BE ADMINISTRATED AT SCHOOL REQUIRE AN AUTHORIZED SIGNATURE OF BOTH THE PARENT/GUARDIAN AND A LICENSED HEALTH PROFESSIONAL**

2. **MEDICATION MUST BE IN A PROPERLY LABELED (see list) ORIGINAL PHARMACY CONTAINER**

    - Student's Name
    - Name and Strength of Medication/Including Dosage to be Given
    - Time and Method of Administration
    - Length of Time/Days to be Given

3. **MEDICATIONS OTHER THEN ORAL, EYE, EAR, OR TOPICAL MAY NEED TO BE ADMINISTERED BY A LICENSED NURSE: EPINEPHRINE AUTO INJECTORS (Epi-Pen, Auvi-Q) ARE AN EXCEPTION. PLEASE CONTACT YOUR SCHOOL NURSE FOR MORE INFORMATION.**

Thank you for your cooperation.

Student Health Services
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