For ____________school year
[expires at the end of August]

PERMISSION TO ADMINISTER MEDICATION AT SCHOOL

PARKWOOD ELEMENTARY 1815 N. 155th Shoreline, WA 98155 SHORELINE SCHOOL DISTRICT	ATTENTION: Rachel Brucker, RN FAX: 206. 393.4158 PHONE: 206. 393 4153

Student ______________________________ Birth date ____________ Grade _________ Age ___________

Parent ______________________________ Address _________________________ Phone _____________

Licensed health professional ___________________________ Phone ______________ Fax _______________

This section to be completed by PARENT or GUARDIAN:

I request that the school nurse, or designated staff member, administer the medication(s) described below as directed by the above licensed health professional. I accept responsibility for supplying the medication in the original container, and for immediately notifying the school nurse (or principal) of any change in these instructions.

☒I give my consent for the confidential information contained on this form to be FAXed to the above named school.

_______________________________________ ____________________

Parent/Guardian signature **Date**

This section to be completed by LICENSED HEALTH PROFESSIONAL:

MEDICATION	DOSAGE	ROUTE	TIME TO BE GIVEN

Health condition requiring administration of medication ________________________________

Possible side effects: ________________________________

Other instructions: ________________________________

I request and authorize that the above-named student be administered the above-identified medication as per the instructions indicated above from [dates] _____________ to ____________ [not to exceed current school year] as there exists a valid health reason which makes administration of the medication advisable during school hours.

___________________________________ ___________________________________ ______________

Signature of Licensed Health Professional with Prescriptive Authority **Name [PRINT OR TYPE]** **Date**

Rev 5/7/03:kj;