
Authorization for Administration of Oral Medication at School

Student Name: _____ Birthdate: _____

School: _____ Teacher/Grade: _____

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**THIS PORTION TO BE COMPLETED BY LICENSED HEALTH PROFESSIONAL WITH
PRESCRIPTIVE AUTHORITY**

Name of Medication: _____ Strength: _____ Dosage: _____

Method of Administration: _____ Time of Day to be given: _____

If to be given as needed (prn), specify minimum length of time between doses: _____

Diagnosis: _____

May student carry inhaler on his/her person? ** Yes ___ No ___

This student has demonstrated to a licensed health professional in my office the ability to correctly administer this medication

Is student trained to self-administer emergency injectable medicine? Yes ___ No ___

Possible side effects of medication: _____

Emergency procedure in case of serious side effects: _____

I request and authorize that the above named student be administered the above identified oral medication in accordance with the instructions indicated above from _____ to _____ (not to exceed the current school year). There is a valid reason which makes the administration of this medication necessary during school hours.

Date of Signature: _____ Signature: _____

Telephone #: _____ Fax #: _____ Print Name: _____

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THIS PORTION IS TO BE COMPLETED BY A PARENT/GUARDIAN

I request and authorize the Willapa Valley School District to administer the above ordered medication for my student in accordance the directions given from _____ to _____ (not to exceed the current school year). Medication will be supplied to the school in the original container with the pharmacy label attached which includes the student's name, medication, dosage and time to be given.

I will allow my student to carry his/her own inhaler: Yes ___ No ___

My student is trained to self-administer their own emergency injectable medication. Yes ___ No ___

Date of Signature: _____ Parent/Guardian Signature: _____

Home Phone #: _____ Work/Cell Phone#: _____