AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student Name: _____ **Grade:** _____ **Birth Date:** _____

□ Edison 807.6223	□ Washington 330.7815	□ WF West 748.3664
□ Fords Prairie 330.7698	□ Centralia Middle 330.7622	□ RE Bennett 748.7256
□ Jefferson Lincoln 330.7803	□ Centralia High 330.7613	□ Olympic 740.1952
□ Oakview Elementary 330.7812	□ Chehalis Middle 740.1849	□ Cascade 748-6167

□ Other _____

Name of Medication	**Dosage**	**Method of Administration**	**Time of Day To Be Taken**
_____	_____	_____	_____

Reason for medication to be given: _____

If given PRN specify the length of time between doses: _____

Indicate if student may carry medication on his/her person: _____

What observable side effects do you want us to report: _____

I request and authorize that the above named student be administrated the above identified oral medication in accordance with the instructions indicated above from _____ to _____ (not to exceed current school year), as there exists a valid health reason which makes administration of the medication advisable during school hours.

_____ _____

Physician Signature Date

Northwest Pediatric Center 360.736.6778 360.736.6552

Clinic Name Phone number Fax Number

This Portion To Be Completed By the Parent/Guardian

I request/authorize the school to administer medication to the above student in accordance with the Physician's instruction from the period _____ to _____ (not exceeding the current school year). I understand that every effort will be made by school staff to administer the medication in a timely manner. The medication is to be furnished by me in the original container, labeled by the pharmacy, with the name of the medicine, the amount to be taken, and the time of day to be taken.

Permission to carry inhaler: □ Yes □ No

_____ _____ _____

Parent/Guardian Signature Date home phone / work phone