

## MEDICATION AUTHORIZATION FORM

Student Name: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_ DOB: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone (Hm): \_\_\_\_\_ (Wk): \_\_\_\_\_

Mercer Island School District No. 400 is authorized by RCW 28A.210.260 State Statutes to administer any prescribed oral medications to students during school hours, only when: 1) The medication is accompanied by a written, current, and unexpired request from a licensed provider, and 2) there exists a valid health reason that makes administration of the medication advisable during school hours. 3) For injectable medications, the Parent Request & Medical Provider Orders for Specialized Medical Treatment form is also required.

Medication requests will be valid only for the medication(s) listed and the dates indicated on District request forms. Requests shall not extend beyond the end of the current school year. Medications must be supplied in their original container with the label indicating the student's name, the licensed provider's name, the dosage, and instructions for administration. Medication may be administered by non-licensed/non-medical school personnel.

When a parent/guardian, provider, and school nurse agree, a student may be allowed to carry and self-administer medication. (See MISD School Board Procedure #5139.2 for a specific allowances)

For your convenience, Medication Requests may be faxed to: School Nurse: MIHS Fax # 206-236-3358; IMS Fax # 206-236-3408; West Mercer Fax # 206-230-6043; Lakeridge Fax # 206-230-6232; Island Park Fax # 206-230-6251

### Medical Provider Request

|   |    |    |
|---|----|----|
| Medication name and strength:             | #1 | #2 |
| Dosage (# of pills/tsp. etc.):            | #1 | #2 |
| Time of administration:                   | #1 | #2 |
| Reason for administration:                | #1 | #2 |
| Side effects:                             | #1 | #2 |
| Known medication allergies:               |    |    |
| Other medications being taken by student: |    |    |

**As physician for this student, I agree he/she is capable of self-administration and may carry the above meds with him/her:**

Yes  No

I request and authorize the administration of the above medication(s) for the period beginning \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ through \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ as there exists a valid health reason which makes administration of the medication advisable during school hours.

\_\_\_\_\_  
(Provider Signature) (Date)

\_\_\_\_\_  
(Type or Print name of Provider) (Phone) (Fax)

### Parent/Guardian Request

I certify that I am the parent, legal guardian, or person in legal control of the above-named student. I request and authorize the Mercer Island School District to administer this medication to the above named student in accordance with the instructions of the authorizing student's provider above. I also authorize the District to enter into a Mutual Exchange of Information with the student's provider named above. I acknowledge receipt of the district's procedures for medication in the school.

**If the provider, school nurse and principal agree, I also give permission for my child to carry and self-administer this medication at school:** Yes  No

\_\_\_\_\_  
(Parent/Guardian Signature) (Date)

\_\_\_\_\_  
(School Nurse Approval) (Date)