

LAKE CHELAN SCHOOL DISTRICT NO. 129
Chelan, Washington

AUTHORIZATION TO ADMINISTER MEDICATION

School _____ RE: Name _____

Birthdate

To: _____

We have been asked to administer medication to the above-named student at school. If this meets with your approval, may we have this order in writing on this form? Medication orders are good for the current school year only unless a shorter period is specified. Thank you for your courtesy.

Date

(Signature of school representative)

Condition requiring medication _____

Drug to be administered _____

Dosage and mode of administration _____

Time of administration _____

Special instructions _____

Duration of order if less than current school year _____

Side effects of the drug _____

I request and authorize that the above-named student be administered the above-identified medication in accordance with the instructions indicated, as there exists a valid health reason which makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials.

Physician's signature _____ Date

Physician's name _____ Telephone _____
(print or type)

Approval of Parent or Guardian

I hereby authorize school personnel to administer the medication identified above to be taken at school as ordered by the student's physician.

Parent's or guardian's signature _____ Date

Note to Parents: All medication must be in the original container and the label must include the student's name, name of the medication, dosage and mode of administration and name of physician.