Mukilteo
School District

OFFICE USE ONLY
Date rec'd:_____
Entered in SIS:_____
Nurse review: _____

Health Services
MEDICATION AUTHORIZATION (Prescription and Non-Prescription)

Student: _____ School: _____

School Fax: _____ School Phone: _____ **DOB:**_____

Teacher: _____ Grade: _____

health care provider complete this section MUST BE TYPED OR PRINTED

Diagnosis or reason for medication: _____

Name of medication_____Dose_____Route_____

Please complete: Daily___ As Needed ___ Time/Directions _____

If medication is to be given as needed, describe indications_____

Possible side effects_____

Is child allowed to possess and self-administer above named asthma or anaphylactic medication?
_____Yes. I have trained this student in the purpose and appropriate method and frequency of use as per RCW 28A.210.
_____No

This medication cannot be scheduled except during school hours.

Health Care Provider **Signature**_____Title_____Date_____

Name_____Address_____

City, Zip_____Phone_____Fax_____

This box must be typed or printed to be valid per state law

parent/guardian complete this section

Under normal circumstances, medication should be administered before and/or after school hours. If a student must receive medication at school, the parent/guardian must submit this written request and authorization. Written directions from the licensed health care provider prescribing within the scope of his/her prescriptive authority must be included. The medication must be provided in the original, labeled container. If for any reason the District questions the identification/instructions of the medicine presented, the District has the authority to withhold administration of the medicine until clarification of the identification/instructions. The District will substantially comply with the schedule of administration indicated by the licensed health care provider. Parent/guardian shall agree in writing that due to school schedules and other factors, administration of dosages may be interrupted.

Having read the above, I hereby request that medication be stored and administered at school. Further, I will hold the District and school personnel harmless from any liabilities that might result from administering the medication, lack of administering the medication or self-administration of asthma or anaphylactic medication.

Parent/Guardian Signature_____Date_____
Home Phone_____Cell Phone_____Work_____

I request that my child be allowed to carry and self-administer his/her prescribed asthma or anaphylactic medicine provided that the conditions of RCW 28A.210.370 are met (see page 2). Parent Signature_____

to be completed by school nurse

Student responsibilities for carrying and self-administering asthma and/or anaphylactic medication:

YES	*NO (date)*	**Student is consistently able to:**
___	___	Identify the correct medication
___	___	Identify the purpose of the medication
___	___	Identify specific symptoms and need for medication administration
___	___	State the correct dosage
___	___	State side effects/adverse reactions to this medication
___	___	Describe what will happen if medication is not taken
___	___	Demonstrate the correct method of administration
___	___	Identify safety issues (i.e., no sharing of medication, safe storage, consistent placement)
___	___	Demonstrate knowledge of how to access assistance from school staff if needed in an emergency

School Nurse Signature_____ Date_____

1. **WHEN POSSIBLE, THE PARENTS AND PHYSICIAN ARE URGED TO WORK OUT A SCHEDULE OF MEDICATION OUTSIDE OF SCHOOL HOURS.**

2. A school nurse often serves more than one school and is not available every day to administer medications. Other school personnel have been trained to provide such required medication when necessary.

3. All medication requires a signed Medication Authorization form (H144) from the parents and licensed health professional prescribing within the scope of his/her prescriptive authority for school personnel to administer the medication. Each medicine prescribed for administration at school requires a separate Medication Authorization.

4. Medication orders must be renewed annually or when a change in medication and/or dosage is made. A new medication form must be completed at the beginning of the school year.

5. Medication must be brought in the original, properly labeled container.

6. Students requiring epinephrine injections for life-threatening conditions (i.e., severe allergic reaction to bee sting and/or food) shall provide the school with EpiPen injectable medication.

7. All medication will be kept in the school office unless otherwise directed by the licensed health professional and the principal.

8. **RCW 28A210.370 Conditions required for self-administration of medication to treat asthma or anaphylaxis:**
   - Medical provider prescribes the medication for use during school hours and instructs the student in the correct and responsible use of the medication.
   - The student has demonstrated to the medical provider (or designee) and to the school nurse the skill level necessary to use the medication and any device that is necessary to self-administer the medication as prescribed.
   - The medical provider formulates a written treatment plan for managing asthma or anaphylaxis episodes of the student and for medication use by the student during school hours.
   - The student's parent/guardian has completed and submitted to school any written documentation required by the school.