

PERMISSION TO ADMINISTER MEDICATION AT SCHOOL

District: West Valley School Dist.	School: West Valley Middle School	Fax: 509-972-5701 Ph: 509-972-5700
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Student: _____ Birthdate: _____ Grade: _____

PARENT/GUARDIAN SECTION * SECCION DE PADRE/GUARDIAN

I request that the school nurse, or designated staff member, administer the medication prescribed below, in accordance with the healthcare provider instructions. **I give my permission for the following medication information to be shared with school staff on a "need to know" basis.**

*Yo pido que la enfermera o personal designado, le administre el medicamento recetada de acuerdo con las instrucciones del medico. **Doy permiso que la siguiente informacion sea compartida con el personal escolar que necesite estar informado.***

FOR INHALERS AND EPIPENS ONLY (PARA INHALADORS Y EPIPENS SOLAMENTE):

I give permission for my student to carry his/her emergency medication. yes no
My student is trained to self-administer their own emergency medication. yes no

*Doy permiso para que mi estudiante pueda traer su medicamento de emergencia. si no
Mi estudiante tiene conocimiento y entrenamiento de administrarse su propio medicamento de emergencia. si no*

Parent/Guardian Signature _____ Date _____ Home phone / Emergency phone
Firma de Padre/Guardian Fecha Telefono de Casa Telefono de Emergencia

HEALTH CARE PROVIDER SECTION

Diagnosis for which medication is to be given during school hours: _____

Asthma Diagnosis: Mild Intermittent Mild Persistent Moderate Persistent Severe Persistent

Name of medication (1 per form): _____ Dosage: _____ Method of administration: _____ Time of day to be given: _____

*If given **prn**, specify length of time between doses:* _____

Other directions for use: _____

Possible side effects: _____ Emergency Action: _____ or 911

Duration of Order (must choose one)

- Medication is ordered for duration of current school year (which may include summer school)
- Medication to be given from _____ / _____ / _____ to _____ / _____ / _____.

FOR INHALERS AND EPIPENS ONLY:

May this student carry his/her emergency medication? yes no
Is this student trained to self-administer his/her own emergency medication? yes* no
***If yes, this student has received instruction in the correct and responsible way to use the medication.**

**FOR STUDENTS WITH ASTHMA OR ANAPHYLAXIS: The HCP must submit
"A written treatment plan for managing asthma or anaphylaxis episodes of the student and for
medication use by the student during school hours" RCW 28A.210.370.**

HCP Signature _____ Date _____
HCP Printed Name _____ Phone _____