

AUTHORIZATION FOR ADMINISTRATION OF ORAL MEDICATION AT SCHOOL CENTRALIA SCHOOL DISTRICT

- | | |
|---|--|
| <input type="checkbox"/> Edison Elementary School - (360) 807-6223 | <input type="checkbox"/> Washington Elementary School - (360) 7815 |
| <input type="checkbox"/> Fords Prairie Elementary School - (360) 330-7698 | <input type="checkbox"/> Centralia Middle School - (360) 330-7622 |
| <input type="checkbox"/> Jefferson Lincoln Elementary School - (360) 330-7803 | <input type="checkbox"/> Centralia High School - (360) 330-7616 |
| <input type="checkbox"/> Oakview Elementary School - (360) 330-7812 | |

Student Name _____ Grade _____ Birth Date _____

THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH PROFESSIONAL

Name of Medication	Dosage	Method of Administration	Time of Day to be Taken
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Reason for medication to be given: _____

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

Inhalers: _____
Indicate if student must carry on his/her person.

Possible side effects of medication: _____

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

I request and authorize that the above named student be administered 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.

 Date of Signature Licensed Health Professional

 Phone FAX Name (Please Type or Print)

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I request the school to administer medication to the above student in accordance with the Licensed Health professional instruction for the period from _____ 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

 Date of Signature Parent/Guardian Signature Home Phone / Work Phone

AUTHORIZATION FOR ADMINISTRATION OF ORAL MEDICATION AT SCHOOL

Student Name: _____ Grade: _____ Birth date: _____

THIS PORTION TO BE COMPLETED BY THE PHYSICIAN/DENTIST

<u>Name of Medication</u>	<u>Dosage</u>	<u>Method of Administration</u>	<u>Time of Day To be Taken</u>
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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.

Date of Signature

Physician/Dentist Signature

Telephone Number

Name (Print of Type)

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I request authorize the school to administer medication to the above identified student in accordance with the doctor's instruction fro the period from _____ to _____ (not to exceed 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 or physician with the name of medicine, the amount to be taken, and the time of day to be taken.

Permission to carry inhaler _____ Yes _____ No.

Parent/Guardian Signature

Date of Signature

Telephone Number Home: _____ Work: _____