CAMAS SCHOOL DISTRICT

School Health Services

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN CAMAS SCHOOL DISTRICT

Student's Name: _____ School Year: _____

DOB: _____ Gr.: _____ School: _____ School Fax: _____

THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH PROFESSIONAL (LHP) PRESCRIBING WITHIN THE SCOPE OF THEIR PRESCRIPTIVE AUTHORITY

Name of Medication: _____

Dosage/Frequency: _____

Diagnosis or reason for medication: _____

If given PRN, specify the length of time between doses: _____

Possible major side effects of medication: _____

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

Student is capable of carrying/administering inhaler Yes ☐ No ☐ and/or Epi-pen Yes ☐ No ☐

BACKUP MEDICATION KEPT IN HEALTH ROOM IS HIGHLY ENCOURAGED!

I request and authorize that the above-named student be administered the above identified oral medication or Epi-Pen injection 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.

Licensed Health Professional	Clinic Name	Date
Name (Print or type)	Telephone	Fax

Please note:

1. Prescribed medication must be provided in the container labeled by the pharmacist with the name of your child, the name of the medication, the dosage and frequency in which the medication is to be given.
2. Over the counter medications must be in the original container.
3. If samples of medication are to be given, they must be labeled with the name of the student, dosage, and time to be given.
4. Medications must be brought to the school by the parent/ guardian.

THIS PORTION TO BE COMPLETED BY THE PARENT/LEGAL GUARDIAN

I request and authorize the school to administer medication to the above identified student in accordance with the health care provider's instructions. I may revoke this authorization by writing to my student's school district. If I did, it would not affect any actions already taken by the school district based upon this authorization.

Once health care information is disclosed, the person or organization that receives it may re-disclose it in conformance with applicable laws. Confidentiality of information provided to my student's school district is protected by the federal Family Educational Rights and Privacy Act. My signature indicates that I understand the district shall incur no liability as a result of any injury arising from the self-administration of medication by the student and parents/legal guardians shall indemnify and hold harmless the district and its employees or agents against any claim arising out of the self-administration of medication by the student. (CSD policy 3419)

You have my permission to communicate with this health care provider in order to make arrangements for the care and supervision of my child. I give the Health Care Professional:

Permission to fax this form to the school	☐Yes	☐No
Permission for my student to carry and self-administer inhaler	☐Yes	☐No
Permission for my student to carry and self-administer Epi-pen	☐Yes	☐No

_____ _____

Parent/Legal Guardian Signature Date of Signature