Oak Harbor School District
AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

STUDENT NAME: ______________________________ **BIRTHDATE:** __________

SCHOOL: ________________________________ **GRADE/TEACHER** ________

THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH PROFESSIONAL WITH PRESCRIPTIVE AUTHORITY

Name of Medication	Dosage/Method of Administration	Schedule (i.e., @lunch, PRN, etc)
______________	______________________	____________________
______________	______________________	____________________

Diagnosis or reason for medication: ____

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

***THIS SECTION IS* REQUIRED IN ORDER FOR STUDENT TO CARRY AND SELF-ADMINISTER INHALER OR EPI-PEN**

Student has been instructed in self-administration by licensed personnel in my office:
__________________________MD/ DO/ ARNP/ PA/ RN/ LPN/ MA. I request this student be allowed to carry and self-administer his asthma inhaler/ epi-pen (circle one) Yes____No_____

Possible side effects of medication: ____

Emergency procedure in case of serious side effects: ______________________________

I request and authorize the above-named student be administered the above identified medication in accordance with the instructions indicated above **from** (date: mm/dd/year) ______________________**to** (date: mm/dd/year) ______________ (not to exceed current school year) as there exists a valid health reason, making administration of the medication advisable during school hours.

________________ Date of Signature

________________________________ Licensed Health Professional Signature

________________ Office Phone

________________________________ Name (print or type)

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I give permission for the school to administer medication to the above-named student in accordance with the LHP's instructions. I understand that every effort will be made by school staff to administer the medication in a timely manner. The medication must be furnished to the school in accordance with district policy outlined on the reverse side of this form.

For asthma inhalers and epi-pens only: (please circle the one your student uses)
I give permission to carry and self-administer his/her prescribed inhaler/epi-pen Yes_____ No _____
Release of liability for self carry and self-administration of inhalers and epi-pens:
I take responsibility for my child's adherence to the dosing schedule; OHSD will not monitor self administration.
__________ **(Parent initial required for student to carry and self administer inhalers/epi-pens)**

__________ **Date**

______________________________ **Parent Signature**

__________ **Daytime Phone**

Student self-administration approved by: ______________________________ RN, School Nurse