



Bellevue School District  
Bellevue, Washington

**AUTHORIZATION FOR ALL (RX and over the counter) MEDICATIONS TO BE TAKEN AT SCHOOL**

**The following section is to be completed by the PARENT/GUARDIAN:**

(please print)

Student's Name: _____		Sex: _____	
_____ Last	_____ First		
School: _____	Grade: _____	Birthdate: _____	
_____	_____	_____	
Health Care Provider's Name	Address	Phone	
Please check the box that applies :			
<input type="checkbox"/> I request that the authorized persons at school assist my child in taking the medicine(s) described below			
<input type="checkbox"/> I request that my child be permitted to medicate herself/himself at school.			
I also give my permission for the exchange of information between the school district staff and the health care provider listed above. I understand that the medication is to be furnished by me in the original container labeled by the pharmacy or prescriber with the name of the medication, the amount to be taken, frequency of administration, and name of health care provider.			
If the parent/guardian elects to authorize the student to medicate himself/herself at school, the parents/guardians shall hold harmless and indemnify the school and Bellevue School District's officers, employees and agents against all claims, judgments, or liabilities arising out of the self-administration and carrying of medication by the above-named child.			
_____ Date	_____ Parent/Guardian Signature	_____ Home Phone	_____ Emergency Phone

**The following section is to be completed by the HEALTH CARE PROVIDER:**

(please print)

Diagnosis for which medication is given: _____	
Name of medicine: _____	Dose: _____
<input type="checkbox"/> Tablet/Capsule <input type="checkbox"/> Liquid <input type="checkbox"/> Inhaler <input type="checkbox"/> Injection <input type="checkbox"/> Nebulizer <input type="checkbox"/> Other _____	
If medicine is to be given <b>DAILY</b> , at what time? _____	
If medicine is to be given <b>WHEN NEEDED</b> , describe indications: _____	
_____	
How soon can it be repeated? _____	
Is child authorized to medicate himself/herself? <input type="checkbox"/> YES <input type="checkbox"/> NO	
If <b>YES</b> , I have instructed this student in the purpose and appropriate method or frequency of use; and student demonstrates necessary skill to use the medication and to use any device necessary to administer medication.	
List significant side effects: _____	
Length of time this treatment is recommended: _____	
Other information: _____	
_____	
Date: _____	Health Care Provider's Name: _____
	Health Care Provider's Signature: _____

**Bellevue School District 405**  
**Policy 4320**

7.0 Administration of oral medication

In the event that there exists a valid health reason which requires the involvement of school personnel in the administration of any medication to a student during school hours or the hours in which the student is under the supervision of school officials, the following procedures shall apply consistent with RCW 28A.210.260 and the Washington State Nurse Practice Act.

7.1 Written authorization. A prior written request and authorization from the parent or guardian and the prescribing physician or dentist must be on file for the following categories of medication. Such requests and authorizations will be effective for the current school year unless a shorter period is specified.

7.1.1 Over-the-counter medication.

7.1.2 Prescription medication.

7.1.3 Epinephrine injection to prevent allergic reactions.

7.2 Persons who may administer

7.2.1 School nurses

7.2.2 Any employee trained and supervised by a school nurse in proper procedures for administration of medication

7.3 Identification and security of medication

7.3.1 All prescription medication must be in the original pharmacy container labeled with the following information:

7.3.1.1 Name of student

7.3.1.2 Name of medication

7.3.1.3 Dosage and mode of administration

7.3.1.4 Name of physician prescribing medication

7.3.2 Nonprescription medication must be in the original retail container.

7.3.3 All medication must be kept in a locked secure place.

7.4 Record of administration

The administration of any dose of medication must be recorded on an individual medication log sheet.