



# Battle Ground Public Schools

P.O. Box 200, Battle Ground, Washington 98604

## Student Health Services Medication in School Form

The public schools recognize the fact that in certain infrequent cases, school children must take oral medication at school. When a health condition requires that a student be given prescription or non-prescription (over-the-counter) medication during school hours, authorization must be given by the child's parent or legal guardian and accompanied by written instructions and the signature of the prescribing licensed health care provider or dentist. The authorization must contain inclusive dates for each medication and any changes in the dosage or administrative instructions as they occur. Only oral medication in containers properly labeled by the licensed health care provider, dentist, pharmacist or manufacturer and brought to school by the parent or legal guardian will be accepted for administration by the school. Asthma inhalers and Epi-Pens are the only exception to having non-oral medications at school. Only trained school district personnel are authorized to administer and monitor oral medication dispensed at school.

### LICENSED HEALTH CARE PROVIDER OR DENTIST REQUEST

**INSTRUCTIONS BY THE HEALTH CARE PROVIDER OR DENTIST:** please provide the following information:

Student's Name \_\_\_\_\_ School: \_\_\_\_\_

Type of Medication: \_\_\_\_\_  Tablet  Capsule  Liquid  Inhaler  Epi-Pen

Reason for Medication: \_\_\_\_\_

Administration (dosage and frequency): \_\_\_\_\_

Additional Instructions: \_\_\_\_\_

Are there side effects of medication?  No  Yes If yes, please explain: \_\_\_\_\_

Dates of duration for administering medication: \_\_\_\_\_

I authorize that \_\_\_\_\_ be administered the identified medication in accordance with the above stated instructions. There exists a valid health reason, which makes administering of this medication advisable during such time as the student is under the supervision of school officials.

It is medically necessary for student to carry asthma inhaler or Epi-Pen on their person.

Signature of Licensed Health Care Provider/Dentist \_\_\_\_\_ Name (Print or Type) \_\_\_\_\_

Date of Signature \_\_\_\_\_ Telephone Number \_\_\_\_\_

I certify that I am the parent or legal guardian of \_\_\_\_\_ and request and authorize school personnel to comply with the instructions as stated above. As a result of this authorization, I agree to indemnify and hold harmless the school district and its employees who may administer and/or monitor any medication. **UNLESS THE PARENT/GUARDIAN NOTIFIES THE SCHOOL, MEDICATION WILL NOT BE GIVEN ON EARLY RELEASE DAYS.**

I give the health care provider permission to fax this form to the school  Yes  No

Signature of Parent/Legal Guardian \_\_\_\_\_ Date of Signature \_\_\_\_\_