Eastmont School District & Wenatchee School District

FOR INHALER PLEASE USE EMERGENCY MEDICATION FORM

Authorization to Administer Medication at School

Student's Name:		Birthdate:		Grade:	

School:		Phone:		Fax:	

Condition Requiring Medication: _____

TO BE COMPLETED BY THE LICENSED HEALTH CARE PROVIDER			
Name of Medication	***Dosage***	***Route***	***Time(s) of day to be given***

Possible side effects/further instructions: _____

****

Condition Requiring Medication_____

_____

TO BE COMPLETED BY THE LICENSED HEALTH CARE PROVIDER			
Name of Medication	***Dosage***	***Route***	***Time(s) of Day to be given***

Possible side effects/further instructions:_____

I request and authorize that the above named student be administered the above identified medication(s) in accordance with the instructions indicated above. Duration of order IF less than current school year (includes summer school). _____

_____ _____

Date of Signature **Licensed Health Care Provider's Signature**

_____

Telephone Number **Fax Number** **Licensed Health Care Provider Name** ***Please Print***

THIS PORTION IS TO BE COMPLETED BY THE PARENT / GUARDIAN

I certify that I am the parent, or legal guardian in legal control of the above identified student and request and authorize the school to administer the above identified medication in accordance with the prescription, or doctor's instructions. Medication must be supplied to the school in the original container labeled with instructions on how it will be given at school. I understand and accept that at times the doses of medication may be delayed or missed due to occasional conflicts in the student's schedule. I give my consent for School District staff to exchange information between the above health care provider and associated school staff regarding the above information.

_____ _____ _____

Print Name Signature Date